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AUTHOR Lonsdale, Alan J.; And Others
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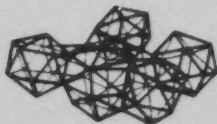
ABSTRACT

The development and testing of procedures and instruments for nursing performance evaluation in Western Australia are described. The approach was used to compare the nursing performance of nine recent graduates of the Western Australian Institute of Technology (WAIT) program and two graduates of hospital-based programs. Background information is presented on changing trends in health care, nursing, and nursing education. The approach involved: interviews with recent graduates and their nursing supervisors; observation of nurse-patient interactions using the Nursing Performance Instrument (NPI); and supervisor ratings and self-ratings of the performance of recent graduates using the Nursing Performance Rating Form. A post hoc analysis of 10 separate nursing contexts was conducted and compared to the five role areas of the Nurses Board Statement of Competencies, which are appended. Information drawn from the interviews of supervisors and graduates was used to examine the socialization influences of the contexts in which graduates were working. No significant differences in the nursing performance of the WAIT college-based course and hospital-based courses were found, but the context in which nursing occurs was found to be an important determinant of performance. Questionnaires and interview questions are appended. (SW)

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WESTERN AUSTRALIAN INSTITUTE OF TECHNOLOGY
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**EVALUATING THE NURSING PERFORMANCE
OF COLLEGE AND HOSPITAL GRADUATES:
PROCEDURES, OUTCOMES AND ISSUES**

**A REPORT OF THE
NURSING EDUCATION EVALUATION PROJECT**

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EVALUATING THE NURSING PERFORMANCE OF COLLEGE AND
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Alan J Lonsdale
Norman C Dennis
Sally Hooke
Christine Norvilas

August 1982

This evaluation study was undertaken for the Nurses Board of Western Australia. It was supported by a grant from the Nurses Board and a supplementary grant from the Commonwealth Tertiary Education Commission. The views expressed in the Report are those of the authors and do not necessarily represent the views or policies of the Nurses Board of Western Australia.

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EVALUATING THE NURSING PERFORMANCE OF COLLEGE
AND HOSPITAL GRADUATES : PROCEDURES, OUTCOMES
AND ISSUES

SUMMARY OF REPORT

BACKGROUND *(p1)

In 1975, the three-year UG2 course in basic nurse education was introduced at the Western Australian Institute of Technology (WAIT). At the time of its commencement, in view of the innovative and experimental nature of the course, a modest evaluation programme was established to provide on-going formative information for the progressive refinement of the course. Over time, the focus turned from an interest in course improvement to the question of the performance of graduates in the work place. This study is concerned with the development of procedures and instruments for the evaluation of nursing performance, and the testing of these with the limited number of WAIT graduates who entered the workforce in 1981 and with a comparison of group of graduates from hospital-based courses.

The study was supported by grants from the Nurses Board of Western Australia and the Commonwealth Tertiary Education Commission's Evaluative Studies Programme. The study was conducted between September 1980 and April 1982.

PURPOSES

It is important to emphasise that the major purpose of this project was the development and testing of procedures and instruments for the evaluation of nursing performance. As the number of WAIT graduates was small (18 entered the workforce in 1981; only 9 were available for evaluation), it is not possible to draw definite conclusions concerning their performance in comparison with hospital graduates. Bearing this in mind the specific purposes of the project were :

- a) to develop criteria, appropriate to Western Australian circumstances, against which the nursing performance of recent graduates could be assessed,
- b) to develop procedures and instruments for the evaluation of the nursing performance of recent graduates from the WAIT programme and from hospital-based programmes,
- c) to apply the Nursing Performance Instrument to the evaluation of nursing performance in the Western Australian situation.

*A more detailed discussion on this part of the summary may be found in the section of the full report commencing on this page.

- d) to pilot the evaluation procedures and instruments with the available WAIT graduates who entered the workforce in 1981 and with a comparison group of hospital graduates, with a view to assessing the effectiveness of the procedures and instruments for the purposes of measuring, evaluating and comparing nursing performance,
- f) to make tentative observations concerning the nursing performance of WAIT and hospital-trained graduates, bearing in mind the limited numbers of available graduates and the primary purpose of developing and assessing evaluation procedures and instruments, and
- g) to make recommendations concerning further studies in the area of the evaluation of nursing performance.

SETTING THE STAGE

The report first discusses the changing trends in health care, nursing and nursing education. These found particular expression in the Goals of Nursing Policy Statement, which recommended that nursing education should be conducted in tertiary educational institutions. The need for evaluative studies for the type reported here grows out of these changes, and was reinforced by a recommendation of the Report of the Committee of Inquiry into Nurse Education and Training ("Sax Report").

In a brief literature review, the results of the previous related studies in Australia and overseas are summarized. Of particular significance to this study is the general observation that few differences are reported between the nursing performance of college and hospital graduates, and that the immediate nursing context and the processes of professional socialization are important determinants of nursing performance. For this reason, the effects of context are examined in some detail in this study, in order to extend previous Australian studies.

CRITERIA AND DATA COLLECTION PROCEDURES

Three main data collection procedures were used :

- a) interviews with recent graduates and their nursing supervisors,
- b) the Nursing Performance Instrument (NPI) in which trained observers record various aspects of nurse-patient interactions over a series of observations using a comprehensive observation schedule, and
- c) the Nursing Performance Rating Form (NPRF). This consisted of two versions, one to obtain ratings of performance by supervisors of recent graduates, and the other to obtain self-ratings of performance by the graduates themselves.

The focus of these procedures is on the process of nursing, rather than on outcomes. Criteria derived from observations of current practice formed the basis for the NPI, which had been developed and applied by the Victorian nursing evaluation team over the past several years. (p20). The NPRF was based on a set of broader criteria. These reflect both direct and indirect contributions to patient care together with other aspects of the role of the nurse consistent with emerging views on the nursing process as an analytical, systematic problem-solving process involving assessment, planning, implementation of care and the evaluation of care. These criteria were derived from a recent Statement of Competencies of the Registered Nurse developed by the Nurses Board of Western Australia. Five inter-related role areas were studied: 'health teacher', 'provider of care', 'co-ordinator of care', 'communicator' and 'a member of the profession'. (pp22-23).

Of the eighteen graduates from the WAIT course who entered the workforce in 1981, nine were available to the study. Each of these was matched with two hospital graduates working in the same context as the WAIT graduate, and who had a similar length of nursing experience. (p25).

DEVELOPMENT OF THE NURSING PERFORMANCE RATING FORM (NPRF)

An initial attempt was made to develop a set of video simulations of nursing performance representative of the five role areas, which would form the basis for assessments of performance by nursing supervisors. Through a series of workshops these were developed, filmed and tested. As difficulties were experienced in the use of this approach (p28), a modified procedure which obtained supervisor ratings on a detailed rating form (NPRF) was developed. The NPRF consists of a set of specific items for each of the five criterion areas, each item being related to an observable dimension or component of the role which is involved in effectively carrying out that role. Supervisors provided ratings of the frequency with which a nurse performed in the manner specified. Ratings took account of the opportunities available to demonstrate a particular competency and the confidence of the supervisor in making the judgements. (pp34-36). To maximize inter-rater reliability and reduce rater error, rater training workshops were conducted (p36).

Self assessments of performance were also obtained from the graduates, using an appropriately modified form of the NPRF (p38).

NURSING PERFORMANCE INSTRUMENT (NPI) (p39)

The NPI was used to obtain a second set of ratings using independent, trained observers. The development of this instrument by the nursing research team at Monash University was based on a set of dimensions of nursing care activities that occur in the presence of the patient, in the form of nurse-patient interactions in which there is a reciprocal exchange between the nurse and the patient, or patient-related actions which do not involve a reciprocal exchange. Each graduate was observed for sixteen periods, each of fifteen minutes' duration. The resulting descriptive information was interpreted and used to provide an evaluation of the nurse's performance on each of fourteen areas of nursing.

NURSING CONTEXTS (p42)

Previous studies have demonstrated the influence of context on nursing performance. While a detailed study of contexts was not an initial aim of the project, information gained through the use of the NPRF and the associated interviews showed that the immediate nursing context affected both nursing performance and the evaluation of performance. A post hoc analysis of the ten separate immediate nursing contexts in which graduates were working was conducted, in relation to each of the five role areas of the Nurses Board Statement of Competencies. The analysis demonstrated substantial differences in expectations in different work settings, varying interpretations of role areas, different approaches to implementing the nursing process and fragmentation of the nursing process which made it difficult to identify the contributions of an individual nurse to any particular phase of the process. The major contribution of beginning nurses was to the implementation phase of the nursing process; they had restricted inputs to the phases of assessment, planning and evaluation. Concerning context, the following conclusions were drawn :

- a) that the manner in which nursing was conducted, and hence the opportunities to display and observe particular competencies, varied substantially from one context to another,
- b) that the actual nursing performance of the graduates was significantly influenced by the immediate nursing context, and
- c) that there was a lack of consistency between the criterion statement (the Nurses' Board Statement of Competencies) and the manner in which nursing was actually practised in particular contexts.

OCCUPATIONAL SOCIALIZATION

Information drawn from the interviews of supervisors and graduates was used to examine the socialization influences of the contexts in which graduates were working. It was apparent that socialization processes were affecting both groups of graduates similarly. Most graduates claimed to be inhibited by the working environment. There was evidence of conformity to and acceptance of prevailing norms and customs, both through formal processes by which hospital or ward procedures and customs were communicated, and through informal daily contacts with supervisors and colleagues, who served to translate into practical terms the demands of the system. At the same time, both groups of graduates displayed a questioning attitude. WAIT graduates, in particular, tended to express frustration at being required to adopt routines instead of using a problem solving approach and working from first principles. Hospital graduates, however, tended to be less questioning in this direction, and were more likely to comment on deficiencies in staffing or equipment as inhibiting the standard of patient care.

RATINGS OF PERFORMANCE

The results of the performance ratings using the NPI and NPRF need to be interpreted with considerable caution, bearing in mind the small number of graduates evaluated, the effects of context on performance and the confounding of performance assessments by contextual factors. Within these limitations, the results of the performance ratings are summarized below.

NPI

Analysis of the observer ratings of performance using the NPI demonstrated that on each of the 14 evaluative scales of the NPI, the mean ratings of the performance of the two groups of graduate nurses were virtually the same.

Both groups scored highest on the same evaluative dimension ("concern") and lowest on the same dimension ("safety"). When the ratings were examined in terms of the actual levels of performance, both groups of graduates performed at either an "acceptable" or "highly acceptable" level on all dimensions. WAIT graduates tended to be rated "highly acceptable" on a larger number of dimensions.

In summary, on the basis of the NPI data for the limited number of graduates available for study, no significant difference was observed in the performance of the WAIT group and the hospital group

NPRF

Analysis of the supervisor ratings for each of the five role areas also demonstrated no significant differences between the two groups of graduates. There was a slight tendency for WAIT graduates to be rated more highly in the areas of Provider of Care and Member of the Profession.

On the self-rating version of NPRF, the two groups of graduates also rated themselves similarly on each of the five role areas. In general, graduates in both groups were considerably more confident in the area of Provider of Care, with 60% rating themselves above average. Conversely, in the areas of Co-ordinator of Care and Member of the Profession, only 25% and 20% respectively rated themselves above average. Graduates saw themselves as operating at a higher level of performance in the areas of Health Teacher and Co-ordinator of Care than did their supervisors, while the reverse occurred for the areas of Communicator and Member of the Profession.

CONCLUSIONS

Three main conclusions have been drawn from this study :

- a) Within the substantial constraint of limited numbers of available graduates, and bearing in mind methodological limitations arising from the influences of context, this study has not demonstrated any significant differences

in the nursing performance of graduates from a college-based course (WAIT) and hospital-based courses. This finding results from comparisons between the performance of WAIT graduates with an average of eight months working experience and hospital graduates with an average of nine months working experience; approximately fifty percent of the hospital graduates were working in the hospital in which they were trained. This is in general accord with the findings of the Victorian study.

- b) The context in which nursing occurs is an important determinant of performance. The Victorian study demonstrated that the performance of hospital graduates tended to be higher if they were nursing in the teaching hospital in which they had been trained. From the Western Australian study it is concluded that the intervening variable, specific nursing context, mediates performance in a way that would render observed actual performance significantly different from potential performance. Put another way, one is also measuring the context in which the nurse works. Performance, therefore, is a combination of ability, opportunity to display competencies and the influence of organizational climate.
- c) In addition to its mediating effect on performance, variations in context also restrict evaluation of the nursing performance of groups, when performance is assessed in terms of criteria such as those contained in the Statement of Competencies of the Nurses Board of Western Australia. It is our view that the contextual factors may be so strong that it may not be possible to demonstrate significant differences in performance between different groups, regardless of the measurement procedures used.

A fourth conclusion emerges from the study, although this was not an original purpose. Graduates were observed in four different types of nursing situations, each within a different hospital. As was to be expected, there were differences between those situations in the manner in which nursing was practised. In particular, there were substantial differences between actual practice and the expected practice (or nursing process) described in the Statement of Competencies of the Nurses Board of Western Australia.

In summary, if nurses are performing different activities, in different situation, with different organizational expectations, then the level of performance of those activities cannot directly be compared unless the nature of the context is also taken into account.

The fact that no significant differences in performance were observed between the two groups could be accounted for in a number of ways. Firstly, it may be that the measurement procedures and instruments were reliable and valid, and were able to measure nursing performance with precision and discrimination. If so, one may conclude that there were in fact no differences in performance between the two groups.

Thirdly, it may be that the two types of graduates are capable of different types and levels of performance (by virtue of their courses of training) but that these differences were obscured by other factors, with the result that differences in actual performance were not observed.

It is our view that a combination of the second and third explanations applies, and that the factors obscuring differences in performance arise from the context in which nursing occurs.

DIRECTIONS FOR FUTURE RESEARCH (p98)

In addition to the conclusions summarized above, a number of recommendations and suggestions are made for activity which might follow this study.

a) The evaluation of nursing performance

It is recommended that further research which aims to compare the nursing performance of graduates from hospital- and college-based courses should make extensive use of qualitative procedures. These should involve interviews with supervisors, graduates, nursing colleagues and others, and observation of the nursing context as well as the nurse at work. This is needed in order to elucidate the relationships between context and performance, thereby enabling the making of more insightful judgements about performance.

b) The further study of the nursing process

It is recommended that descriptive studies be made of nursing in a variety of contexts, and from both hospital and community settings, to ascertain the relationships between the nursing process and the actual practice of nursing.

c) Follow-up studies of graduates

In view of the influence of context early in the career of a graduate, it may be that differences in courses are expressed through the career patterns, attitudes, satisfactions and aspirations of graduates some years after graduation. It is recommended that a series of follow-up studies of graduates from both types of programmes be implemented to obtain information on the reasons for career patterns and the attitudes, satisfactions and aspirations of graduates.

d) The further use of NPRF

It is recommended that the NPRF be adapted for use in various schools of nursing or other nursing situations to improve performance evaluation.

e) Professional socialization

It is recommended that further studies of the socialization process be conducted, to seek answers to the following questions:

- i) What is the impact of both types of programme and of the hospital and clinical settings on the professional socialization of nurses?
- ii) What are the influences and effects of socialization on the work and professional attitudes of beginning nurses?
- iii) A socialization process also occurs in nursing education programmes whether based in colleges or hospitals. What is the nature of this process through, for example, the effects of lectures, staff ideologies and attitudes or instructional approaches? In particular, the clinical experiences within courses warrant special attention, in order to examine the effects of these experiences in shaping professional expectations, perspectives and attitudes.

ACKNOWLEDGEMENTS

This report represents the culmination of far-sighted and persistent efforts by Miss Merle Parkes, foundation Head of the School of Nursing at the Western Australian Institute of Technology, to secure support for a substantial study which would provide evaluative information concerning the outcomes of the Institute's programme for the basic education of nurses. Through her efforts, financial support was provided by the Nurses Board of Western Australia for the first phase of 18 months of the project from September 1980 to February 1982. The assistance of the Board is gratefully acknowledged.

In July 1981, the scope of the project was extended through additional funding provided by the Commonwealth Tertiary Education Commission's Evaluative Studies Programme; this is also gratefully acknowledged.

At various times during the project, advice and support were provided by an Advisor Committee consisting of members drawn from the Nurses Board of Western Australia, The Royal Australian Nursing Federation, The Department of Health and Medical Services (WA), directors of nursing and hospital administrators. Thanks are extended to the Committee for their invaluable support and assistance.

The contributions of numerous individuals, both during the planning and development phase and the data collection phase, have been considerable. Miss Parkes and her staff provided continuing support and encouragement throughout the course of the project; their assistance is gratefully acknowledged. It is with sincere appreciation that thanks are also recorded for the involvement and contribution of the many practising nurses and nurse educators who attended workshop sessions, the staff of Mt Henry Hospital, the supervisory staff who served as observer-raters in hospitals, and especially the graduates whose performance was monitored and who participated in the data collection. Directors of Nursing and other administrative staff in the four hospitals which participated in the project were most co-operative and helpful in enabling access to the graduates and their supervisors, and in providing time release for supervisors to participate in training workshops.

Particular thanks are due to the Monash University Nursing Research Team (Dr John McArthur, Ms Anne Brooke and Ms Nina Bruni), who gave permission for the use of the Nursing Performance Instrument (NPI), provided considerable assistance to the planning and conduct of the NPI component of the study, and conducted the training course for the nursing observers used in the WA study.

The sterling efforts of research assistants Sally Hooke and Christine Norvilas and of the nursing observers, are gratefully acknowledged. They worked diligently and with resourcefulness and initiative, in a project which proved particularly demanding and challenging. Finally, sincere thanks are extended to the persons whose typing skills (and patience!) were put to the test as they worked through numerous drafts to achieve the final end product : Peggy Marrett, Marie Goss and Jean O'Connell.

ADVISORY COMMITTEE FOR THE PROJECT

Miss Olive Anstey	Director of Nursing Sir Charles Gairdner Hospital
Miss Rosalind Denny	Director of Nursing King Edward Memorial Hospital
Mrs Pauline Lambert	Principal Education Officer Nurses Board of Western Australia
Dr Mark Liveris (Chairman)	Chairman, Division of Health Science Western Australian Institute of Technology
Dr Richard Lugg	Assistant Director Public Health Department
Mr Bernard McKenna	Nursing Officer Royal Australian Nursing Federation in Western Australia
Miss Merle Parkes	Head, School of Nursing Western Australian Institute of Technology
Mr Neville Rees	Medical Superintendent Royal Perth Hospital
Miss Mary Reid	Director of Community Nursing Department of Health and Medical Services (WA)
Miss Marea Vidovich	Nursing Officer Royal Australian Nursing Federation
Miss Dorothy Wheatley	Principal Nursing Officer (Education) School of Nursing Sir Charles Gairdner Hospital

CHAPTER 1

INTRODUCTION

1.1 BACKGROUND

In 1975, the three-year UG2 course in basic nurse education was introduced at the Western Australian Institute of Technology (WAIT). It was one of the first programmes of its type to be established in a College of Advanced Education in Australia. The structure and content of the course arose from an extensive analysis of existing and future health care and nursing needs in Australia, and of nursing education programmes overseas.

The resulting course seeks to provide, in a multi-disciplinary tertiary institution, a comprehensive approach to nursing education which aims to produce competent nurse practitioners able to apply the nursing process to the care of individuals and families in a variety of nursing situations. Emphasis is placed on the integration and application of knowledge and on problem-solving skills. Particular emphasis is placed on the psycho-social aspects of health care. Structured clinical experience is obtained in a variety of hospital and community situations, in a manner which integrates conceptual and theoretical studies with the development of nursing skills.

At the time of its commencement, in view of the innovative and experimental nature of the course, a modest evaluation programme was established by the Institute, the main aim of which was to provide on-going formative evaluation information to achieve the progressive refinement of the course. Over time, the focus turned from an interest in refining the course to the question of the performance of graduates in the workplace, and by Kratz (1979) and Dennis (1981) represented the first systematic attempts to obtain information of this type.

These various evaluation efforts were strongly encouraged by Miss M E Parkes, foundation Head of the School of Nursing at WAIT, who also actively sought external assistance to support the conduct of a substantial study. A grant of \$18,150 was obtained from the Nurses Board of Western Australia in September 1980, enabling the appointment of a two-thirds time research assistant for eighteen months.

The major purposes of the study funded by the Nurses Board of Western Australia were to develop criteria for the evaluation of nursing performance, and to develop and test measuring instruments and procedures appropriate to the Western Australian context.

These purposes reflect two important factors. The first is that ultimately, the aim of the research programme was to obtain comparative information on the nursing performance of graduates from the WAIT (college-based) programme and graduates from hospital-based training programme, with a view to assisting decision making concerning nursing education in Western Australia and Australia. The second factor concerns the number of graduates available for an evaluation study. The numbers of graduates from the WAIT programme in the years 1977 - 1980 are shown in Table 1.1.

TABLE 1.1 WAIT graduates 1977 - 1980

<u>Intake year</u>	<u>Number of graduates</u>	<u>Year of normal entry into workforce</u>
1975	15	1978
1976	15	1979
1977	10	1980
1978	18	1981

The 1975-6-7 intake groups had been subjected to a considerable amount of evaluation activity in earlier studies, and for this reason were not included in this project. Although 18 members of the 1978 intake group graduated, as detailed later in this report, not all were available for evaluation in 1981. It is therefore important to emphasize that while the various evaluation instruments and procedures developed and used in this study were applied to the available WAIT graduates who entered the workforce in 1981, the numbers are too small to enable any firm conclusions to be drawn concerning comparative nursing performance.

Commencing in 1974, a substantial amount of research has been conducted in Victoria to evaluate college-based nursing education programmes and their graduates. Support for most of this work has been provided by the Commonwealth Tertiary Education Commission's (CTEC) evaluative studies programme. The main approach used by the Victorian team for the evaluation of nursing performance was the Nursing Performance Instrument (NPI), which had been developed over a number of years and applied to several groups of graduates. It was considered important to apply the NPI in the Western Australian context, so as to obtain information which would relate directly to that emerging from the Victorian studies, and to allow for the more comprehensive piloting and cross-validation of research procedures in Western Australia. For these reasons, in July 1981 a grant of \$11,300 was provided by the CTEC to augment that provided by the Nurses Board of Western Australia. This enabled the appointment of a second, half-time research assistant. To accommodate the additional research activities, the duration of the overall project was extended to April 1982.

1.2 PURPOSES OF THE PROJECT

The purposes of the project were:

- a) to develop criteria, appropriate to Western Australian circumstances, against which the nursing performance of recent graduates could be assessed,
- b) to develop procedures and instruments for the evaluation of the nursing performance of recent graduates from the WAIT programme and from hospital-based programmes,
- c) to apply the Nursing Performance Instrument to the evaluation of nursing performance in the Western Australian situation,
- d) to pilot the evaluation procedures and instruments with the available WAIT graduates who entered the workforce in 1981 and with a comparison group of hospital graduates, with a view to assessing the effectiveness of the procedures and instruments for the purposes of measuring, evaluating and comparing nursing performance,
- e) to examine the influences of the immediate nursing context on nursing performance, and on the evaluation of nursing performance,
- f) to make tentative observations concerning the nursing performance of WAIT and hospital-trained graduates, bearing in mind the limited numbers of available graduates and the primary purpose of developing and assessing evaluation procedures and instruments, and
- g) to make recommendations concerning further studies in the area of the evaluation of nursing performance.

1.3 ADVISORY COMMITTEE

An Advisory Committee, consisting of senior representatives from the areas of nursing, nursing administration and nursing education, provided support and guidance to the project. The main functions of the Advisory Committee were:

- a) to offer advice on the purposes, nature, conduct and outcomes of the project, and to facilitate communication with relevant authorities, institutions and professional groups, and
- b) to assist the project through the provision of information, and through securing access to facilities and people necessary to the conduct of the project.

1.4 PROJECT STAFF

The project was directed by Mr Alan Lonsdale and Dr Norman Dennis, both of whom are attached to the Educational Development Unit at the Western Australian Institute of Technology.

Miss Sally Hooke was appointed as two-thirds time research assistant in September 1980. Mrs Christine Norvilas joined the research team as a half-time research assistant in July 1981.

For the NPI component of the project, a group of nursing observers was trained and assisted the project over a period of two months. This group consisted of Mrs Penelope Easton, Mrs Nola Hansen, Mrs Marion Rodino and Mrs Sandra Wilkins.

1.5 OVERVIEW OF THE REPORT

Consistent with the primary purposes of the project, a substantial portion of the report is concerned with a description and discussion of the research procedures and instruments.

To provide a backdrop to that discussion, Chapter 2 considers some of the emerging issues with respect to nursing and nursing education, and relates these to the significance of this project. A brief review of the literature on the evaluation of nursing performance is also included.

Chapters 3 and 4 focus on the research design and the development of research procedures and instruments. The rationale for the research design is described, together with the steps involved in the development of the Nursing Performance Rating Form. Since this instrument was based on performance criteria developed for nursing in Western Australia, it constituted the main evaluation instrument for the study. A brief description of the Nursing Performance Instrument is also provided.

As the project progressed it became clear that the influence of the immediate nursing context was substantial. Context influences the actual performance of graduates in the working situation, and also affects the process of evaluation. For this reason Chapter 5 is devoted to a description of the immediate nursing contexts in which graduates were working, and an examination of the relationships between context and occupational socialization. In the light of this discussion, the specific results obtained from the performance measuring instruments are provided in Chapter 6.

Finally, the overall conclusions emerging from the study are presented in Chapter 7, together with suggestions for further research.

CHAPTER 2

SETTING THE STAGE

2.1 INTRODUCTION

The current debate in nursing education reflects the different views which prevail about how nurses work and how they should be prepared. The study reported here represents one attempt to provide an empirical base that will allow a more informed debate to be pursued. Furthermore, since the study relates specifically to the evaluation of the nursing performance of graduates of hospital-based and multi-purpose college-based programmes, it has provided the opportunity to examine nursing contexts and to solicit the opinions of practising nurses. This has revealed areas of difference and competing values and attitudes.

In order to provide a backdrop against which this evaluative study has been conducted and reported, it is appropriate to highlight some of the major issues and concerns that have been raised in the debate on future directions for nursing practice and education. In the first part of this chapter an attempt is made to set out some of these issues. In the latter part of the chapter a brief review of previous related studies is provided.

2.1 THE NEED FOR CHANGE : TRENDS IN HEALTH CARE AND NURSING, AND CHANGING EXPECTATIONS

The changing philosophy of health care which emerged during the seventies found strong support, particularly among members of the nursing profession. This new outlook emerged as health professionals began to analyse and interpret changing community needs and expectations. Patten (1979) referred to :

- i) pressures from the community for improved health services,
- ii) changing attitudes within the community which reflected an enlightened opinion about patients' rights, about quality of care, and about accountability,
- iii) pleas for greater community involvement, through community-initiated and managed health-care centres,
- iv) the growing emphasis on health education programmes and
- v) the shift away from curative and solely institutionalized services to preventive services, with an emphasis on total primary health care.

The changes in health care were accompanied by a parallel set of trends in the practice of nursing. Firstly, the adoption of a philosophy of primary care brought with it the need to make patients more self-reliant, and to have them assume a more responsible role in promoting their own health. Nurses were thus to be cast in the much-neglected role of health teacher. Secondly, an orientation towards primary health and patient-centred care was to demand a related shift away from task-oriented nursing care. An expanded role for the nurse, to include the prevention of illness, the provision of leadership in health education in the community, and the exercise of professional responsibilities (either individually or collectively and as members of a health care team) was thus seen to have special implications for the education of nurses.

2.3 THE GOALS OF NURSING POLICY STATEMENT

The changing trends in health care and nursing found expression in the Goals of Nursing Policy Statement. Formulated in 1976 by organizations involved in nursing across Australia, the "Goals" were to provide direction and targets for nursing education. The changes that were proposed incorporated the changing philosophy of nursing (and

health care generally) and demanded the transfer of nursing education programmes from the traditional apprenticeship mode into tertiary educational institutions.

... basic nursing programmes which prepare professional nurses should be conducted by multi-discipline education institutions at a level no less than a tertiary diploma (UG2) and provide both breadth of education and comprehensive nursing preparation. (Goals of Nursing, 1976, Supplement, p.3)

Two implications which derive from this statement are :

- i) that the UG2 Diploma should be the minimum award, since such a programme would provide for breadth and depth of knowledge and appropriate clinical experience, and
- ii) that the preparation of those entering nursing should be placed in the tertiary education sector; in other words, health care employing authorities should not continue to be responsible for the education of their future employees.

The demand for a common tertiary-based education was seen as a sine qua non for equipping the graduate nurse with the required theoretical understanding and repertoire of skills that would be needed to perform effectively in an expanded role. However, serious doubts were raised in some quarters as to whether such a nurse might be more effective and efficient than her hospital-trained counterpart.

2.4 CHANGING CURRICULA IN NURSING EDUCATION: THE NEED FOR EVALUATION

A translation into practice of the "Goals of Nursing" had resulted in the design of new programmes for the preparation of nurses. These programmes incorporated changes that were intended to provide the benefits of learning as students rather than as providers of a service, in the milieu of a multi-disciplinary educational setting. An issue that had been a bone of contention over the years - that student nurses were the only health professional group to be educationally

disadvantaged by being prepared in isolation - was claimed to have been finally addressed. The changes in nursing education programmes were to provide the student nurses with a more rigorous and academically sounder theoretical basis. In addition, it was :

...no longer sufficient to prepare nurses whose concepts of health care and nursing are dominated by the curative services and, in most cases, the specialist acute general hospital services, at the almost total expense of the broader context of health care. (Patten, 1979, p.37).

The expectation that those nurses must be more than technically competent has also been expressed elsewhere :

In every setting where nurses work, their practice involves assessing the health care needs of the individuals or groups in their care, ...planning ... with patients, clients and families, and with other health professionals involved how best these needs may be met, ... implementing the plan of care and, ... evaluating the care given.

This implies that nurses have the same level of professional responsibility and accountability to the patient or community groups as the other health professionals and must be able to work in a colleague relationship with them ... it does imply that they are competent to make a nursing diagnosis, determine what is appropriate and therapeutic nursing in the situation and, in communication with other personnel involved in the care, plan, implement and evaluate the health care programme. (Slater, 1978, p.42).

The expectations and claims made in respect of nursing education programmes provided by tertiary education institutions, have led to the raising of a number of questions. How do we know that the college-trained nurse will be superior to her counterpart trained in a hospital-based programme? Furthermore, is there any evidence to support the claims made for college-based programmes? How does the 'new' nurse compare, in her performance, with the nurse who has been trained in accordance with the hospital-based apprenticeship model? According to Parkes (1982, p 18) an analysis of extant research findings suggests :

... that comparative studies which measure the effect of an educational programme merely on the performance of tasks, provide misleading conclusions and misconceptions of the purpose of a tertiary nursing programme. (p.18)

This question of nursing performance is the focus of the present study, which combines the data gathering procedures and instruments used by the Monash nursing research team (Mackay, Brooke and Bruni, 1981) with additional approaches and instruments designed for the Western Australian situation. These additional research procedures have been used in an attempt to complement the focus on task-oriented activities and behaviours, and to obtain some measure of other behaviours manifested in nursing practice which would be indicative of an expanded, primary care role.

Finally, this study is supported by a recommendation of the Sax Report (1978) :

Basic nurse education should also continue to be offered in three-year diploma (UG2) courses ... each of these approved programmes should have sufficient students to enable proper comparisons with good hospital schools of nursing to be made. (Recommendation IV - p.118).

2.5 LITERATURE REVIEW

In the literature on the assessment of performance in the health professions, authors seldom fail to comment on the dilemmas faced by those who conduct the evaluations. Performance evaluation will always remain a complex process, plagued by a number of problems. In the evaluation of nursing performance this is no less true, even though the process may be prompted by the simple question: "How well is the nurse performing in the working situation?"

From the substantial literature available on the assessment of nursing performance only a few studies will be considered in this chapter . These have been chosen for their relevance to the major purposes of the Nursing Education Evaluation Project in that they are concerned not only

with evaluating the performance of the graduate nurse immediately following registration, but also with the comparison of the nursing performance of graduates from hospital-based programmes and alternative programmes.

In their publication Learning to Nurse, Allen and Reidy (1971) reported on the first five years of the Ryerson Nursing Programme. This thoroughgoing and comprehensive study addressed such issues as the course itself, the student in the course, staff and student perceptions, attitudes and beliefs, and the performance of graduates in the working situation. The study employed a variety of data gathering tools and procedures, including self report inventories, questionnaires, and rating and attitude scales.

Based on the data, the authors derived a composite picture of the Ryerson nurse at work. Evaluative comments from directors of nursing and head nurses suggested they were favourably impressed by the graduates. Their agreement on the strengths and weaknesses of the graduates was summarised as follows:

On the one hand, she is flexible, adaptive and independent. She is able to think things through, applies basic principles and is willing to learn. She is articulate and uses supervisory staff for support and reference. She respects herself and her patients, is interested in her patients, is able to give emotional support to them. She is an eager young woman skilled in the communication arts who fits well into the work world. On the other, she lacks self-confidence, is initially slower in procedures, needs extra help in taking charge, and in the eyes of the directors of nursing, has not had enough experience.

Her performance compares favourably with that of the average young hospital graduate. She feels she likes nursing better, and is able to give good emotional support. She is less confident of herself but still better able to "stand up" for herself. She is, if less efficient, more adaptive and willing to learn. (Allen & Reidy, 1971, p. 242).

In a study which formed part of the ongoing monitoring and evaluation of the WAIT nursing course, Dennis (1981), reported on the WAIT nurse graduate in her first year at work. Using an interview approach, with questions similar to those in the Ryerson study, this investigation took advantage of the first opportunity to find out how employers felt about

the competencies and attitudes of thirteen WAIT nurses during their first year at work. Interviews were conducted with senior nursing staff at two hospitals employing these WAIT graduates. As in the Canadian study, the impressions of the hospital staff were, overall, favourable and positive. It was agreed that WAIT nurses conveyed a keen and intelligent attitude, displayed a deeper theoretical knowledge, adapted easily to new roles, were supportive and considerate of the needs of patients, were able to adjust well, over time, to demands of their work settings, and displayed maturity and eagerness to continue to learn.

Criticism regarding inadequacies and shortcomings centred typically around the organisational and technical aspects of the work of the nurse. It was felt that supervisory skills and those of ward administration were generally weak. Also, it was agreed that while the WAIT course offered scope and depth of theoretical knowledge, this was at the expense of mastering practical skills and routines. This "shortcoming" was seen as an important explanation for the beginning nurse's over-cautious attitude, her initial lack of confidence, her insecurity and her lack of ability to organise ward routines.

The 1977 and 1978 graduates from the WAIT course totalled 30, of whom 25 were employed within Australia in 1979. In a study undertaken by Kratz (1979), 10 of the 25 employed graduates were observed and interviewed, and a further 10 were interviewed. Kratz reported on the myth of the WAIT "supernurse" and the unrealistic expectations of directors of nursing as well as the traditionally trained nursing colleagues. She found that WAIT nurses were capable of adequate performance when functioning in a normal situation. They also performed routines and procedures in a thoughtful manner, suggesting that they were not slavishly tied to routine. Problems were noted to arise as the WAIT graduates faced the pressures and demands of busy ward administration: they tended not to cope in such situations, to become overwhelmed, and to forsake the maxim of working from first principles. As predicted (possibly because this was implied through the philosophy, structure and content of the WAIT nursing course) the WAIT trained nurse performed particularly well in the areas of the use of psycho-social skills in dealing with patients, interpersonal relationships in dealing with

people with whom she is in daily contact, working relations with colleagues and other professionals, and in expressing concern for the welfare of patients.

However, an area in which the WAIT nurse failed to live up to expectations was in assessing patients' needs and planning care. Kratz related two incidents in this regard in which she evidenced compliance and conformity. She suggested that beginning nurses would naturally tend to take on the characteristics required by the settings in which they worked because of their lack of security and their need for affiliation and for gaining acceptance by their colleagues. She also concluded that the information assembled through her study was reasonably consistent with findings from other studies. In particular, this applied to the perceptions of WAIT graduates about difficulties experienced during their first year of nursing, their observed nursing performance, and ratings of their nursing performance.

Of particular interest are Kratz's comments on what she regarded as probably the most interesting outcome of her study:

I was at first disturbed by the 'ordinaryness' of the nurses whom I was observing. They were charming people but apart from some insecurity in knowing the routine appropriate for a junior sister and in their ability to delegate work to other people, they were behaving very much like anyone else. Only slowly did I appreciate that this very ordinaryness was a measure of their success, at least from their perspectives. What they were trying to prove was they were like other nurses of their rank and seniority, that having been prepared at WAIT did not mean they could not pass in the work world. (Kratz, 1979, p.18)

This important issue is taken up further in Chapter 5, where the process of occupational socialization is discussed in relation to nursing contexts.

The first major Australian reports on comparisons of the performance of nurses from hospital based and college based programmes were produced in Victoria (Mackay, Brooke and Bruni, 1981; McArthur, Brooke and Bruni, 1981). Few significant differences in the performance of the two types

of graduate were discovered. These studies reported that college graduates performed more adequately than hospital-based graduates in such areas as interpersonal relationships, concern for patients, the provision of individualised nursing care and the education of patients in health care. They were rated as equally adequate in areas of technical and procedural skills, patient welfare, and safety and professional competence. However, in the areas of organisational ability, speed and confidence, and efficiency in the execution of daily routines and procedures, college graduates were rated as performing less adequately than their hospital counterparts. These ratings, particularly those indicating a performance level somewhat below that of the hospital graduate (for example, inability to budget time efficiently and lack of confidence in organisational aspects of ward management) had also been corroborated by ratings obtained from supervisors.

The McArthur, Brooke, and Bruni (1981) study summarised the general lack of difference between the college and hospital graduates in the following manner:

The overall conclusion of these general comparisons was that in the sample observed there were few observable differences on the fourteen evaluative items between college and hospital graduates.
(p20)

A further consistent finding which emerged from the Victorian studies was that the nursing environment in which the assessment occurred unmistakably influenced nursing performance. Hospital graduates scored highest on the performance rating instrument in most categories of performance when observed in the teaching hospitals in which they had completed their basic course of training. On the other hand, college graduates tended to display greater flexibility and capacity to adapt when observed in the unfamiliar work settings of non-teaching hospitals. This finding served to raise several questions concerning nursing context which were further explored in this study, and which are discussed in more detail in Chapter 5.

CHAPTER 3

RESEARCH DESIGN

3.1 INTRODUCTION

This chapter describes the research design used in this study and the rationale underlying the design. Detailed information concerning the development and nature of the research instruments is provided in Chapter 4.

As described in the introductory chapter, the central concern of the study is the assessment of the nursing performance of graduates from different nursing education programmes during their first year of nursing as registered nurses, that is, in the first year after completion of their courses. To do so, it is necessary to answer the following questions:

- a) which aspects of nursing performance are to be assessed; what is an appropriate sample of nursing competencies on which evaluative judgements may be based?
- b) what - and whose - criteria should be used in judging performance?
- c) what instruments and procedures may be used to measure performance?

Before considering these questions in some detail, it is necessary to clarify the situation concerning the question of cause and effect.

3.2 CAUSE AND EFFECT

Of particular interest to nurse educators are answers to such questions as : Which aspects of the course resulted in nursing performance of a particular nature and quality? Which aspects of the course are working effectively? In what ways might the course be improved?

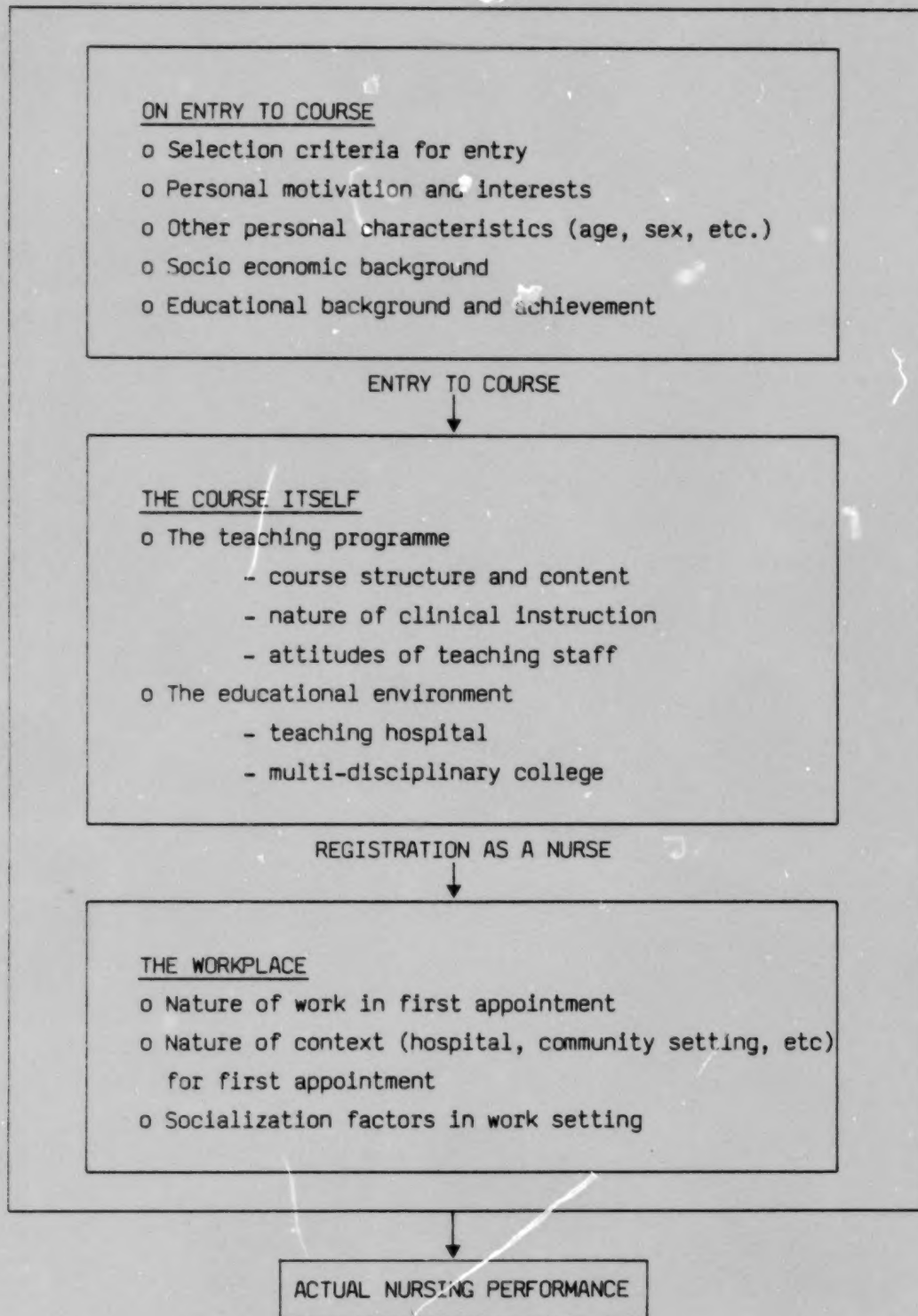


Figure 3.1 Factors affecting nursing performance during first year after registration

Any differences in the nursing performance of registered nurses from hospital-based and college-based schools of nursing could be attributable to one or more of a variety of factors, as shown in Figure 3.1. Regardless of the nature of the educational programme and the personal and educational characteristics of students on entry to the course, influences and experiences deriving from the working situation may affect actual nursing performance as observed in the workplace.

An experimental or quasi-experimental design involving a longitudinal study of one or more cohorts of entering students would be time-consuming as it would need to extend over several years, and would require larger numbers of graduates than those available from the WAIT programme. The rationale adopted for this study treated the combined "entry", "course" and "post registration" factors as a total system. Accordingly, the basic question with which this study is concerned may be expressed as : Regardless of the manner in which students are selected, their characteristics on entry to the course, or the nature of the educational programme, in what ways, if any, do graduates from the WAIT course differ from graduates from hospital based courses, in terms of their actual performance in the working situation? It is therefore not possible to conclude from this study that any observed differences between the two types of graduate are attributable to the courses as such.

Previous studies (for example, Kratz, 1979; Harrington and Theis, 1968; Watson, 1978; McArthur, Brooke and Bruni, 1981) have demonstrated that contextual factors operating in the working situation may be important determinants of nursing performance. Accordingly, an attempt was made in this study to determine the nature and extent of the effect of context, and the interaction between contextual factors and nursing performance.

3.3 FRAMEWORK FOR EVALUATION

Approaches to the evaluation of nursing fall into either of two classical frameworks. In general terms, one approach is to focus on the outcomes of nursing care. In outcome evaluation, specified patient outcomes are identified and their achievement is assessed. Alternatively, process evaluation is concerned with examining and making judgements about what is done by the person providing nursing care. Over recent years there has been increasing encouragement to utilise the outcome framework in evaluation as it argued that, in the final analysis, this is the most valid approach; ultimately, the effectiveness of nursing is reflected in outcomes (for example, Taylor, 1975; Zimmer, 1974).

In comparing these two frameworks for evaluation it is important to consider the purpose of the evaluation. In distinguishing between process and outcome evaluation, Bloch (1975) makes a further distinction. Measurement of process may occur through a focus on the care given by a nurse or through a focus on the care received by a patient. In the former, the competency of the individual nurse is assessed and the resulting information is useful in evaluating the nurse. A well known example of this is the Slater Nursing Competencies Rating Scale, an instrument developed for measuring the actions and interactions of nurses when providing nursing care (Wandelt and Stewart, 1975). The latter is illustrated by the Qual Pacs instrument (Wandelt and Ager, 1974) which was adapted from the Slater Scale by converting the nurse-oriented items to patient-oriented items. It is the former approach which is more pertinent to this study.

Almost invariably, evaluations of the nursing performance of individual nurses utilise the process approach. While the outcome approach may be appropriate to the evaluation of nursing care provided by a system (a ward, a hospital, a group of nurses, a medical team), it is less appropriate to the evaluation of the performance of individual nurses. Apart from the difficulties of establishing appropriate outcome

criteria, there are two important reasons for concentrating on process evaluation in this study. Firstly, the outcomes of nursing care are usually a product of the contributions of a number of individuals, not all of whom are registered nurses; there are, therefore, difficulties in attributing outcomes to the contribution of any one individual. Secondly, nursing research provides very few reliable links between process and outcomes.

3.4 CRITERIA

If the relationship between process and outcomes is weak, what criteria should be used in assessing nursing performance? In essence, two approaches may be used. Firstly, criteria may be derived from current practice, through observations of what nurses actually do when nursing. In this way, the elements or components of nursing care which are to be evaluated may be identified. Standards of performance against which such evaluations may be made are usually derived from judgements by experts, that is from those qualified to make valid assessments, for example, experienced practising nurses, nursing administrators, or nurse educators. Secondly, criteria may be developed from expressions of what ought to be rather than what is observed to be, that is through an examination of the literature on the philosophy and practice of nursing, which in turn is reflected in specific statements of competency or statements on standards of practice.

Both approaches were used in this study. Criteria derived from observations of current practice formed the basis for the Nursing Performance Instrument (NPI) developed and applied by the Victorian nursing evaluation team over the past several years. Because the NPI had undergone extensive development and had been applied to the evaluation of nursing performance with several cohorts of Victorian graduates under the Commonwealth Tertiary Education Commission Evaluative Studies Programme, it

was considered desirable to take advantage of this developmental work and to obtain comparative data concerning Western Australian graduates.

In essence, the NPI focuses on direct nurse-patient interactions and utilizes trained observers who record, interpret and evaluate nursing activities that occur in the presence of the patient. Further information on the NPI is provided in Chapter 4; a detailed description of the instrument occurs in Mackay and Brooke (1979).

The use of the NPI was augmented by a second approach, the Nursing Performance Rating Form (NPRF), which differed from the NPI both in terms of the manner in which criteria were established, and the manner in which data were collected. The rationale underlying the criteria used in this second approach is now discussed.

One difficulty in establishing process criteria is that there is not universal agreement on what constitutes desirable nursing practice and, in turn, appropriate criteria for the evaluation of nursing performance. Depending on their particular philosophies about nursing and the health care process, different individuals and groups (practising nurses, nursing administrators, general practitioners, nursing educators) identify different sets of competencies as being representative of "nursing", assign varying levels of importance to different competencies and would expect differing levels of performance on these. Such judgements are based on underlying and usually inarticulated assumptions, rationale and values.

The nursing process is based on interactions. The design for the NPRF component of this study recognises two basic categories of interaction :

- a) direct interactions between the nurse and the patient, and
- b) interactions with other persons encountered during the nursing process, for example, with other nurses, nursing supervisors and others in the health care team.

In addition, in any working situation, the role of the nurse (and hence the components to be considered in evaluating nursing performance) also includes other types of activity which contribute indirectly to the quality of nursing care. For example, various aspects of communication, such activities as planning, record keeping and personal management, contributions to improving the operation of the nursing service in which she is working and other professional activities need also to be considered. Accordingly, in seeking evaluation criteria it was necessary to accommodate activities relating directly to nurse-patient interactions and interactions with others, together with other aspects of the work of the nurse not related directly to individual patient care. It was also considered important that the criteria used should reflect emerging views on the nursing process as an analytical, systematic, problem-solving process involving assessment, planning, implementation of care and the evaluation of care.

A recently developed statement of "Competencies of the Registered Nurse", developed by the Nurses Board of Western Australia (1980) to provide guidelines both for nursing education and the assessment of nursing performance, was utilised as the basic statement of criteria for the NRPF component of this study. This statement was chosen because it satisfies the various requirements expressed above and, importantly, because it constitutes the basis upon which graduating nurses are registered in the State of Western Australia. Further, the statement was the result of an extensive process of inquiry and discussion over a period of about twelve months, in which a wide range of nurse-practitioners, nursing administrators and nurse-educators was consulted. In compiling the statement a detailed study was also made of previously developed statements of competency, the most pertinent of which were the College of Nurses of Ontario "Standards of Nursing Practice" (1976), the American Nurses Association (1973) statement on standards of practice, and

reports from the Nursing Council of New Zealand (1979, 1980), the Registered Nurses Association of British Columbia (1978) and the National League for Nursing (1978).

The Nurses Board statement identifies specific competencies within five inter-related roles: 'health teacher', 'provider of care', 'co-ordinator of care', 'communicator' and as 'a member of the profession'. Within the 'provider of care' area a set of essential intervention skills is also specified. A copy of this statement appears in Appendix 1.

Items in the statement are expressed in reasonably broad terms, for example, "as a health teacher the nurse implements teaching plans that are specific to the client or patient level of development and knowledge", or "as a communicator the nurse uses appropriate lines of authority and communication within the work setting". It is important to note that these statements are not expressed in terms of how teaching plans are to be implemented, or how lines of communication and authority within the work setting are to be utilised. As Scriven (1981) points out, different specific actions can have the same equally satisfactory outcomes. In developing the NPRF evaluation criteria therefore, an attempt was made to operationalise the Nurses Board of Western Australia statement in a manner which did not rely on the detailed way in which a function was performed. For example, without specifying precisely how communication with relatives should be achieved, it is possible to determine the extent to which opportunities to do this are acted on and, in broad terms, the nurse's effectiveness in performing this role.

3.5 DATA COLLECTION PROCEDURES

Three main procedures were used in this study:

- a) interviews with recent graduates and their nursing supervisors,

- b) The Nursing Performance Instrument, which utilises trained observers who record various aspects of nurse-patient interactions over a series of observations using a comprehensive observation schedule, and
- c) the Nursing Performance Rating Form, which consisted of two versions - one to obtain ratings of performance by supervisors of recent graduates, and the second to obtain self-ratings of performance from the graduates themselves.

Many approaches to the evaluation of nursing performance which focus on process are available. These include the analysis of critical incidents, interviews, the conduct of nursing audits, patient interviews, observational procedures, simulations of nursing situations and a variety of rating scales, checklists and questionnaires completed by nurses themselves, by their supervisors or by others. The full range of approaches is not reviewed here. It is important, however, to provide a brief discussion of the relevant advantages and disadvantages of observational approaches and ratings by supervisors.

The most important questions concern the validity and reliability of measurement. An observational approach such as the NPI, utilizing trained observers who carry out observations according to a carefully designed schedule, can result in maximization of the reliability of measurement. In the development of the NPI, estimates of reliability within and between observers were high (Mackay and Brooke, 1979). The validity of an observational approach is dependent, among other factors, on the specific criteria used by the trained observers in making evaluative judgements, the comprehensiveness of their observations in relation to the role of the nurse, and the extent to which the observers are unobtrusive, both to the nurses being observed and their patients.

Validity is maximized if measurements are made in the actual working situation in as unobtrusive a manner as possible. Obtaining the ratings of supervisors who are able to

unobtrusively observe the work of the nurse over an extended period of time may appear to overcome some of the problems associated with the observational approach. However, the validity of supervisor ratings can be significantly affected by the personal values of the rater, and the nature of the work situation may be such that supervisors may not have opportunities to observe, even over an extended period of time, the full range of competencies. Achieving inter-rater reliability is also more difficult.

Both the observational and the supervisor rating approaches (and any others) are fraught with difficulties. In using two complementary approaches based on quite different principles, an attempt has been made in this study to obtain a closer approximation to reality.

3.6 GROUPS STUDIED : MATCHING PROCEDURES

In determining the research design, the main focus of the study was the entire available population of graduates from the WAIT School of Nursing course for the Diploma of Applied Science (Nursing) who completed the course in 1980 and entered the workforce in 1981. The normal year of entry into the course for this group was 1978.

The group comprised eighteen graduates. Of these, nine were available to the study. Following completion of their course, the remainder rapidly became dispersed in Western Australian country areas, interstate and overseas, or took positions which were inappropriate to the study (one travelled overseas, three commenced nursing in NSW and Tasmania, two accepted positions in W.A. country hospitals, one commenced specialized work with the Alcohol and Drug Authority and one commenced full-time study in the field of psychiatric nursing). All available WAIT graduates were interviewed by telephone in December 1980 - January 1981.

To enable comparisons to be made between graduates from the college-based course and hospital-based courses, a matched hospital group was also studied. Following procedures developed by the Victorian nursing research team (Mackay, Brooke and Bruni, 1981), for each WAIT graduate studied, two hospital graduates were also studied. The Victorian work had demonstrated the importance of context in influencing nursing performance; for this reason the matched pairs were drawn from the same working situation during the main data collection period (September - November 1981). For example, if a WAIT graduate was working in a surgical ward at a small metropolitan teaching hospital, an attempt was made to study two hospital graduates working in the same ward in the same hospital, who had a similar length of nursing experience. In some instances this strict matching procedure was not possible because of hospital staffing constraints; the hospital group is perhaps best described as one closely matched with the WAIT group wherever the opportunity allowed.

For the WAIT group, the average length of post-registration nursing experience at September 1981 was approximately eight months. For all but one member of the hospital group the average experience was approximately nine months (the remaining hospital graduate had been nursing for nine years).

Some of the graduates selected were not available at the time of data collection; the actual numbers for whom data were collected are shown in Table 3.1.

Table 3.1 Number of graduates Studied

Procedure	Number of graduates studies	
	WAIT group	Hospital group
Nursing Performance Instrument (NPI)	9	17
Nursing Performance Rating Form (NPRF)	8	13
Interviews of supervisors & graduates	8	13

3.7 FURTHER COMMENT ON THE PURPOSES OF THE PROJECT

The point has already been made that the major purpose of this study was the development and testing of criteria, procedures and instruments which may be used to measure nursing performance in the working situation. The limited number of graduates available reinforces the caution required in drawing from this study any substantive conclusions concerning relative performance. In applying the instruments with the available graduates, the main purpose was to enable an evaluation of the research procedures.

Further (as will be explained in more detail in Chapter 4), while the main research procedures were quantitative in nature, a substantial amount of qualitative information was also collected through interviews and questionnaires, in order to provide insights into the interactions between context, socialization and performance. This aspect of the study was essentially illuminative in nature, following a number of the principles of illuminative evaluation described by Parlett and Hamilton (1976).

CHAPTER 4

RESEARCH INSTRUMENTS AND PROCEDURES

4.1 INTRODUCTION

An important purpose of this study was the development of instruments and procedures for the measurement of nursing performance. An account is given in this chapter of the development and use of the instruments utilised in the study. In particular, steps leading to the development of the Nursing Performance Rating Form (NPRF) will be described in some detail. A briefer description of the Nursing Performance Instrument (NPI) is provided as descriptions of its development are available elsewhere (Mackay, Brooke and Bruni, 1981; Mackay and Brooke, 1979).

To enable the various research procedures described in this chapter to be seen in overall context, a summary of the steps involved in the study is shown in Figure 4.1.

4.2 VIDEO-TAPED NURSING SITUATIONS

As discussed in the previous chapter, an important component of this study involved the development of supervisor rating procedures. These sought to obtain assessments in relation to the full range of criteria which were based on the actual nursing performance of graduates over a period of time, from those best in a position to provide these - the supervisors of the recent graduates.

For both the observational approach (NPI) and the supervisor rating approach, ratings are obtained at different times and in different contexts, and are based on different aspects of nursing performance. In other words, while the measuring instrument may be 'standard' (as is the case with trained observers, but less so with supervisors) the actual items of

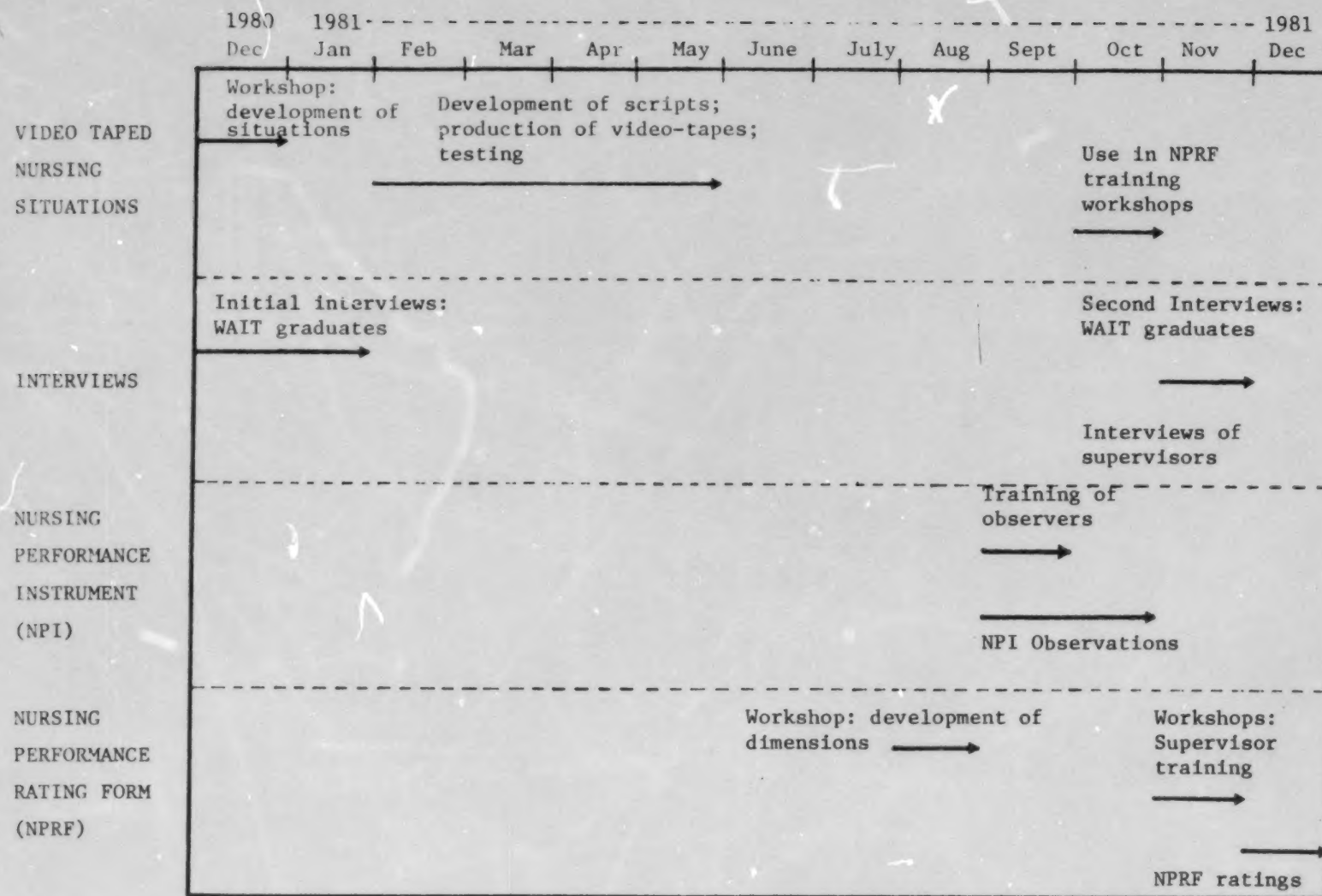


Figure 4.1 Summary of research steps

behaviour being observed may vary substantially. Problems therefore arise in terms of the comparability of ratings from one graduate to another.

In an attempt to reduce this problem and at the same time complement the use of the Nursing Performance Instrument, it was decided to experiment with the use of video-taped nursing situations through which a standardization of the rating situation could be achieved. The rationale is summarised in the following way :

Observational Approach
(e.g., NPI)

Standard measurement procedures using constant trained observers, applied to nurses in different situations.

Supervisor Ratings Using
Video Simulations

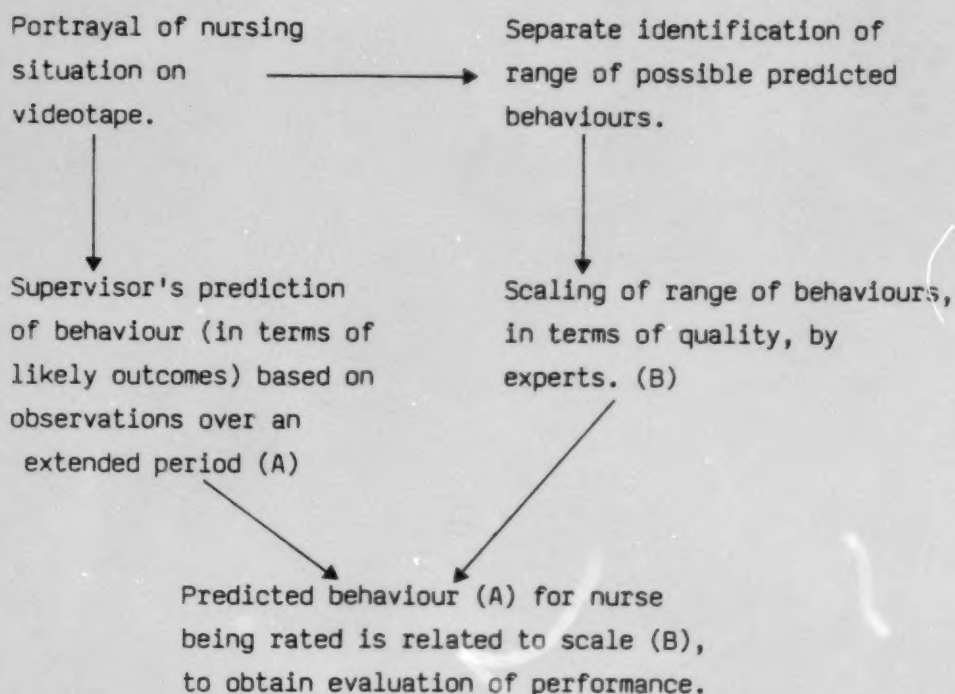
Non-standard measurement (that is, ratings by different supervisors), but based on standard situations.

To achieve this, a series of brief "trigger films" in the form of simulated nursing situations, each portraying representative situations for each of the five criterion areas of the Nurses Board Statement of Competencies, was developed.

For each film the supervisor of a graduate being rated would be asked to visualise the nurse in a situation similar to that portrayed in the film. The situations portrayed are such that there would be a high likelihood that supervisors would have observed graduates in situations similar to those portrayed. On this basis, the supervisor would be asked to predict the likely behaviour or performance of the graduate nurse if placed in this or a similar situation. These predictions would be made in terms of the likely outcomes of the nurse's actions. As explained by Mackay and Brooke (1979), intervening variables such as individual differences between patients, the activities of other health team members or other contextual factors mean that the outcomes of a particular segment of nursing care are

not always directly observable or predictable with certainty; a judgement on likely outcomes is therefore necessary.

It is important to note that this procedure requires the supervisor to predict performance in terms of likely outcomes but not to evaluate performance. The predictions provided by supervisors would then be related to a separately developed scale in which the range of possible responses had been scaled by an independent group of nursing experts. The series of steps is summarised below :



While this procedure was subsequently abandoned and the trigger films used for a different purpose, a number of important observations emerged from the development and piloting of the procedure which may be helpful to others seeking to further develop such an approach. This developmental work is therefore briefly described.

To develop a set of representative nursing situations for each of the five criterion areas, a workshop was conducted in December 1980 involving 30 senior nurse practitioners and nurse

educators. For each situation, the possible range of consequent nurse behaviours was identified and preliminary indications of the relative desirability of these were obtained. The developed situations and behaviours were designed to ensure discrimination between nurses performing at varying levels of competence.

Arising from this workshop, eighteen separate situations were scripted, comprising at least three for each criterion area. Using drama students, each was produced as a one to three minute portrayal on colour television.

The trigger films were piloted in a small suburban hospital. This exercise established that a) each film was consistent with the intended criterion area in that it elicited responses from supervisors relating specifically to the intended area of performance, b) supervisors considered the films to be realistic and representative of typical nursing situations, and such that there was a high degree of likelihood that they would have the opportunity to observe nurses in the same or similar situations, and c) supervisors themselves felt comfortable with the process of "predicting" the performance of graduates.

However, analysis of the supervisors' responses, together with further testing of the trigger films, led to the identification of the following problems :

- a) For any one situation, a considerable range of alternative predicted behaviours was possible. Similar outcomes could result from quite different predicted behaviours; alternatively, depending on the circumstances similar behaviours could result in quite different outcomes. As a result, difficulties were experienced in the identification and scaling of the alternative responses for each portrayed situation.
- b) There was a distinct tendency for supervisors to respond in an holistic manner to each of the situations. For example,

a typical comment was "Nurse X is a good nurse, who nurses well. If placed in that situation I would therefore expect her to perform in the following manner -----".

- c) Difficulties were also experienced in ensuring that supervisors separated the prediction of performance in terms of likely outcomes, from a judgement of quality of performance made in terms of what supervisors personally considered to be good or poor nursing practice. It was also apparent that personal relationships between supervisors and nurses were affecting supervisor judgements in some cases.

For these reasons it was recognised that training programmes would be necessary to ensure that the rating procedure was properly followed.

- d) Although the developed trigger films were typical of the five criterion areas, their limited number meant that they were not representative of the full range of role dimensions across the five areas.

The conclusion drawn was that it was necessary to develop further instrumentation to complement or replace the trigger films as a means of obtaining supervisor assessments. This needed to avoid the conceptual problems referred to above, be more fully representative of the specific components in each of the five criterion areas, and take account of the context in which the performance was assessed.

4.3 THE NURSING PERFORMANCE RATING FORM (NPRF): SUPERVISOR ASSESSMENT

Development and Description

The NPRF was derived as an adaptation of a behaviourally anchored rating scale (BARS). BARS have been the subject of considerable developmental research in order to produce rating procedures for use by, for example, supervisors, in a manner which reduces the problems of rater bias and enhances the

reliability and validity of rating. The NPRF development was based on an analysis of the literature on BARS (for example, Jacobs, Kafry and Zedeck, 1980; Kingstron and Bass, 1981) and the closely related and earlier work on the development of behavioural expectation scales (BES) (Smith and Kendall, 1963).

Through the conduct of a further workshop in August, 1981 involving nurse practitioners and nurse educators, and on the basis of an analysis of previously developed rating forms and competency statements, the basic dimensions involved in each of the five criterion areas of the Nurses Board Statement of Competencies were identified. Because of the unique nature of the Nurses Board Statement only limited assistance was available from the literature for this task. For each criterion area, workshop groups identified actual situations or incidents in which they had observed a nurse performing that role. By examining a range of different nursing situations for each criterion area, underlying components or dimensions of performance were identified. These formed the basis for the development of the Nursing Performance Rating Form. A copy of the form is provided in Appendix 2.

The features of the NPRF are as follows :

- a) The NPRF consists of a set of specific items for each of the five criterion areas or roles, with each area being contained on a single page of the form. Each item relates to an observable dimension or component of the role which is involved in effectively carrying out that role. So far as possible, specific items are discrete and independent of other items.
- b) Each item is expressed in a manner which identifies the nature of the specific role component but does not specify how this component is performed. For example, within the criterion area (role) of Health Teaching, item 4 is :
"tailors explanations to suit the individual level of

understanding of patients". In practice, there are various ways in which this aspect of the teaching of patients might be conducted, depending, for example, on the particular style and personality characteristics of the individual nurse, prevailing circumstances or available resources. In this example, the concern is to assess the extent to which, in the provision of health teaching, the nurse actually tailors explanations in a manner which suits the individual level of understanding of patients, but not to assess the specific means whereby she might do this.

- c) Depending on the particular nursing context, actual opportunities to demonstrate specific competencies may vary. In certain work situations opportunities to demonstrate particular competencies may be limited. To account for this factor, a section of the form sought judgements from the supervisor of the extent to which the nurse had the opportunity to demonstrate the specific competency.

For those items for which such a judgement was appropriate, the supervisor was asked to assess the extent to which "the RN has had the opportunity to demonstrate these behaviours", using the categories 'frequently' 'occasionally', 'rarely' and 'never'.

- d) Within this framework, each item on the N^o seeks an assessment of how consistently the nurse utilizes the opportunities available to perform in the manner described, using the categories 'consistently', 'frequently', 'occasionally', and 'rarely'. An additional category, 'insufficient observed', was included to accommodate the situation where the person making the judgement might consider that he or she had not been in a position to observe the nurse sufficiently to be able to make an assessment on that item.

- e) For each role area, further information was sought to assist interpretation of the specific judgements. This included a general rating by the supervisor of the relative importance of the role area in the work of any nurse, a rating of the importance of the role area in the work of the nurse being assessed, an overall indication of the supervisor's opportunities to observe the nurse working in the role, and an assessment of the supervisor's confidence in making informed judgements in this case.
- f) Finally, for each role area an overall judgement of the quality of performance was obtained, on a scale which sought to relate performance to outcomes. This arrangement sought to ensure that the supervisor, in making the overall rating for any area, did so in the light of a consideration of the specific components involved in the role area in a manner consistent with the intentions of the Nurses Board Statement of Competencies.

In summary, NPRF obtains ratings by supervisors of the frequency with which a nurse performs in the manner specified on various dimensions of nursing performance. Ratings are obtained in a manner which takes account of the opportunities available to demonstrate a particular competency and the confidence of the supervisor in making the judgements.

Training Workshops

In order to minimize rater error and maximize inter-rater reliability, training workshops were conducted for all supervisors. A number of studies (for example, Brown 1968; Ivancevich, 1979; Latham, Wexley and Pursell, 1975) have shown that training sessions have the effect of reducing rater inaccuracy arising from halo effect, leniency error, central tendency error, contrast and similarity effects. The most effective training took the form of intensive workshops giving raters experience in practising ratings, together with the

provision of immediate feedback on ratings. The design of the training workshops for this study was based, in part, on the procedures developed by Borman (1975), Zedeck and Baker (1972) and Latham, Wexley and Pursell (1975). Ivancevich (1979) and Borman (1975) had also found that rater training to reduce halo and leniency effects may be at the expense of reliability and validity; accordingly, the training sessions developed for this study contained additional components aimed at maximizing reliability and validity.

All supervisors participated in a three-hour workshop conducted in the hospital situation. Four workshops were conducted, each containing between six and twelve participants. The purposes of the workshops were a) to familiarize supervisors with the five competency areas of the Nurses Board Statement of Competencies and to seek a common interpretation and understanding of the areas, b) to familiarize supervisors with the operation of the NPRF instrument and provide practise in its use, c) to provide training in order to reduce specific rater errors, and d) to discuss the overall purposes and procedures of the study and to make arrangements for administration of the NPRF.

The first section of each workshop involved the use of the trigger films developed in this project to illustrate and enable discussion on the specific performance components involved in each of the five competency areas. Participants were then introduced to the NPRF instrument and, working in pairs, used the instrument to rate the performance of actual nurses with whom each member of a pair was familiar (but not nurses who were participating in the project). Comparisons of these ratings led to discussions on the various sources of rater error, and assisted a common understanding of the meanings of specific NRPF items. Following these discussions, further practice ratings were made, compared and discussed.

Administration and Interviews

As soon as possible following the training workshops, supervisors used the NRPf to rate the performance of the graduates involved in the study. For each graduate, independent ratings were obtained from the charge nurse and the second-in-charge. The timing was such that raters were either currently supervising the graduates, or had done so very recently - in each case, for a period of at least 6 - 8 weeks. Completed rating forms were returned to the research team for checking and initial analysis. Each supervisor was then interviewed to follow up any apparent inconsistencies in the ratings, to explore in some depth the bases underlying the ratings, and to identify difficulties in the use of the form. In particular, further information was sought concerning the specific context in which the graduate was working and the opportunities to observe performance. (The interview schedule is shown in Appendix 3). A supervisor questionnaire on the organization of patient care in the situation in which the graduate was working was also administered (Appendix 4). Finally, each supervisor was asked to provide an overall rating of performance on a five point scale.

4.4 THE NURSING PERFORMANCE RATING FORM : SELF ASSESSMENT, AND SECOND INTERVIEW

Self assessments of performance were obtained from the graduates, using a suitably modified form of the NRPf (Appendix 5). At the same time (which coincided with the supervisor ratings and interviews), graduates were interviewed, using an interview schedule which paralleled that used with supervisors (Appendix 3). These interviews sought perceptions of personal strengths and weaknesses and the extent to which the nurse felt she was able to work to her full capacity, in the context of the particular nursing environment in which she was working. A self-assessment of overall nursing performance was also obtained.

4.5 NURSING PERFORMANCE INSTRUMENT*

The Nursing Performance Instrument (NPI), developed by a research team at Monash University, was used to obtain ratings of the actual performance of hospital and college graduates using independent trained observers. Ratings were made in September-October 1981.

The Nursing Performance Instrument is based on a set of dimensions of nursing care which were developed through an analysis of video-recordings of actual nursing activities in a Melbourne hospital. Using this information, groups of practising nurses, nurse administrators and nurse educators identified underlying dimensions of nursing care together with judgements concerning the quality of nursing care. From this analysis were derived 109 descriptions of instances of nursing activities that occur in the presence of the patient - either in the form of nurse-patient interactions in which there is a reciprocal exchange (verbal or non-verbal) between the nurse and the patient, or patient related actions which do not involve a reciprocal exchange.

The 109 descriptions of instances of nursing activities were organized into a descriptive schedule, which was used by observers to describe the frequency with which particular instances occurred in the nursing situation.

Each graduate (WAIT and hospital) was observed for sixteen periods, each of fifteen minutes duration usually over a three day period. Observers worked in pairs, and eight separate observations were made by each observer.

* The NPI is a complex and sophisticated instrument. Of necessity, it is only briefly described here; a full description of the development and manner of use of the instrument, the observer training programme and the reliability of NPI is provided in Mackay and Brooke (1979).

Immediately following each fifteen minute observation period, the descriptive information in the form of frequencies was interpreted in terms of the extent of likely contribution to patient outcomes or the extent to which a particular characteristic (for example, dexterity, confidence) was present or absent. A separate interpretative form was used for this purpose, containing 23 interpretive scales :

- Dignity
- Sensitivity
- Rapport (Nurse/Patient)
- Concern
- Patient Co-operation
- Anxiety
- Reassurance (two scales)
- Body Image
- Physical/Emotional Ease
- Health Education
- Independence
- Relatives
- Comfort
- Safety
- Efficiency
- Co-operating as a member of nursing team
- Co-operating as a member of health team
- Dexterity
- Gentleness
- Thoroughness
- Confidence
- Speed

This interpretative information was in turn used by the observer to evaluate the nurse's performance in each of fourteen areas of nursing, which fall into three categories :

Interpersonal Skills

Skill with interpersonal relationships

- Ability to provide individualised nursing care
- Professional competence
- Health education
- Sensitivity
- Concern
- Co-operating as a member of a health team
- Confidence

Technical Skills

- Skill with procedures
- Safety
- Speed
- Comfort
- Efficiency

Organizational Skills

- Organizational ability

The nurse's performance in each area was rated on a four-point scale : 'highly acceptable', 'acceptable', 'barely acceptable' and 'unacceptable'. An additional category of 'insufficient observed' was also available.

Immediately prior to the collection of the NPI data the observers, each of whom was an experienced, registered nurse, underwent an intensive four day training programme conducted by the project officers from the Monash nursing research team.

CHAPTER 5

THE NURSING CONTEXT

5.1 INTRODUCTION

The nursing context has been mentioned by Mackay, Brooke and Bruni (1981) as having a significant impact on nursing performance. These workers examined the effects of context in a macro sense, for example, in terms of whether graduates were working in the hospital in which they were originally trained. The term "nursing context" refers, in this study, to the immediate context of the ward in which the individual nurse works. This chapter deals specifically with problems associated with evaluating nursing performance in the work setting, when a major purpose of such an evaluation is to make comparisons between nurses. No previous studies have been found in which the influences of context on performance and the resulting implications for performance evaluation are examined in any detail.

The focus of this study was evaluation of the nurse at work, as a basis for assessing performance of beginning registered nurses. As has been explained elsewhere, the criteria against which performance was evaluated were derived from the Nurses Board of Western Australia Statement of Competencies of the Registered Nurse. In order for a valid and meaningful comparison to be made it has to be assumed that these criteria are representative of the range of skills or competencies the beginning nurse will exhibit in the working situation. A second assumption, which is relevant to this chapter, is that such competencies are demonstrable in the work setting by the nurse whose performance is being evaluated. Thirdly, it is assumed that the Nurses Board Statement of Competencies is a valid description of the role of a registered nurse, such that

the performance of any individual nurse in the work setting may be gauged against it. However, if these assumptions do not hold, distinct problems arise for an evaluation study of this type. These problems are illustrated in Figure 5.1 and are further elaborated on in the discussion which follows.

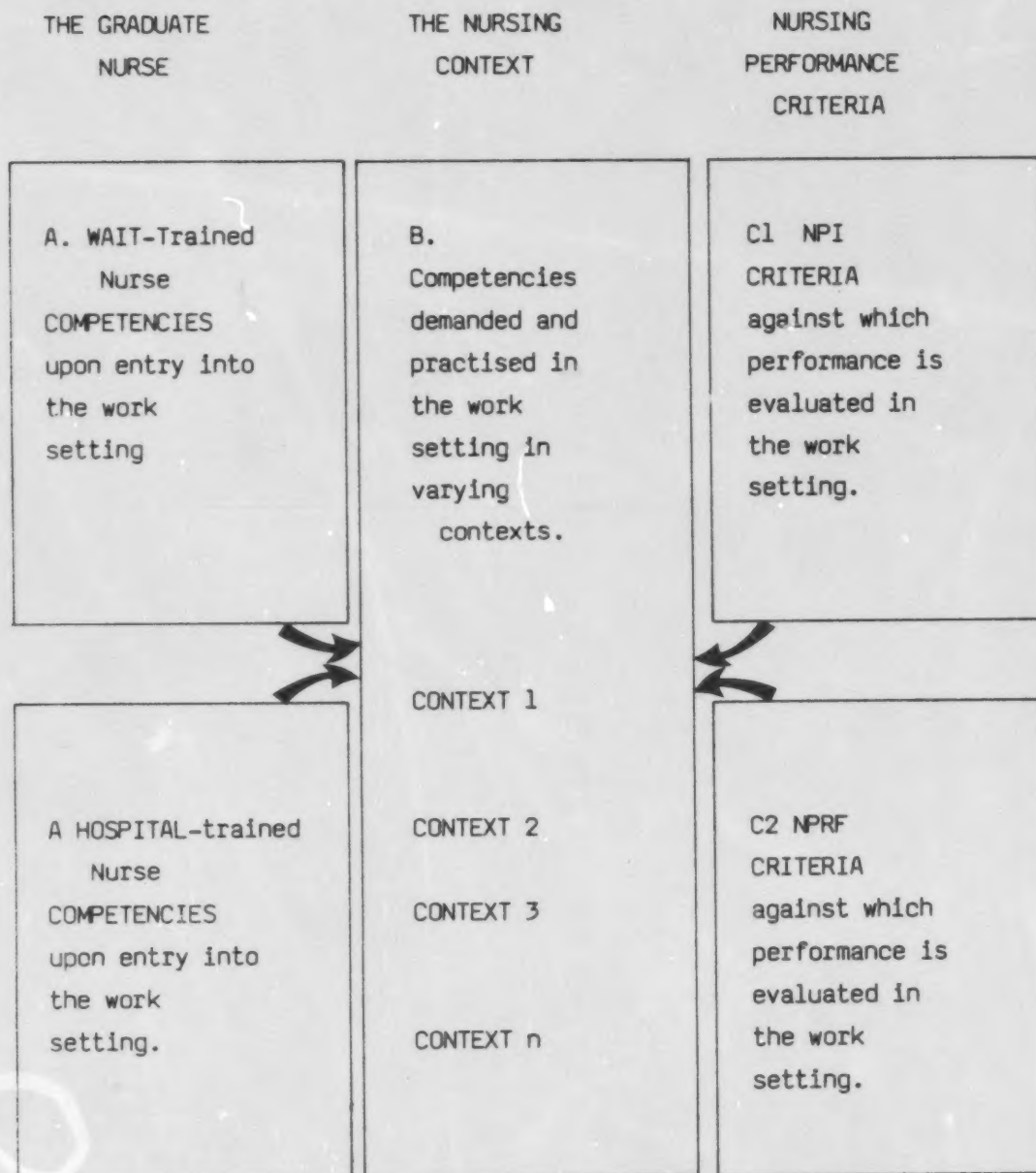


Figure 5.2 Relationships between competencies of the beginning nurse on entry into the work setting, and the criterion competencies.

Problems : Type 1

'A' competencies may not be equivalent to 'B' competencies because

1. 'B' requires the practice of some competencies relevant to the role of the nurse in which the nurse has not been prepared during her training;
2. 'B' does not require practice of all the competencies relevant to the role of the nurse in which the nurse has been trained.

Problems : Type 2

'A' competencies may not be equivalent to 'C' competencies because

1. 'C' requires the evaluation of competencies relevant to the role of the nurse in which the nurse has not been prepared during her training;
2. 'C' does not require the evaluation of all the competencies relevant to the role of the nurse in which the nurse has been trained.

Problems : Type 3

'B' competencies may not be equivalent to 'C' competencies because

1. 'C' requires the evaluation of competencies which the nurse is not required to practice or which she has limited opportunities to display, because of the expectations of her role in a particular work setting;
2. 'C' does not require the evaluation of all competencies relevant to the role of the nurse in the work setting.

Although the Type 1 and Type 2 problems are relevant to this study, their consequences are discussed elsewhere in this report. The main thrust of the present discussion concern the Type 3 problems, that is, the relationships between the evaluation criteria and the competencies practised in the work setting, and the resulting implications for the interpretation of performance data.

Before embarking on a full discussion of these problems, it is necessary to reiterate three further assumptions. The first is that the specific nursing contexts are comparable, enabling data from the different contexts to be combined. Secondly, it is assumed that the contexts afford opportunities for the desired competencies to be demonstrated. The third assumption is that the criterial competencies are readily observable in the work setting by those who must evaluate the nurse's performance.

5.2 THE NPRF: PROBLEMS OF CONTEXT AND RELEVANCE OF CRITERIA

It was known from the outset of the study that the demands and expectations of particular nursing contexts would be important in determining the opportunities that nurses had to demonstrate various competencies. However, there was no specific intention to examine individual nursing contexts in any depth. The NPRF sought to have the raters distinguish between actual opportunities the nurse had to perform specified behaviours and the consistency with which an individual nurse actually performed these. It was therefore expected that having controlled for context in this way, the performance data would enable direct comparisons to be made between nurses, regardless of the individual wards in which they worked.

During the study, it was found that the five role areas of the Nurses Board Statement of Competencies were relevant to all contexts. However, the interpretations given to these roles and the extent to which opportunities were provided for the nurse to display specific competencies were largely determined by the

particular nursing contexts. The central role of Provider of Care illustrates the dilemmas quite well. Firstly, there were differing role expectations in different work settings. Secondly, these prevailing expectations and customs provided particular frameworks in which the Nurses Board Statement was translated; this meant that meaningful comparisons between the performance of nurses were not possible. Thirdly, the nursing process was implemented differently in different wards, being largely a function of ward management and administration. It was noticeable that there was fragmentation of the nursing process, in a way that made it difficult to identify the contributions of an individual nurse to any particular phase of the process. Fourthly, the major contribution of beginning nurses seemed to be largely to the implementation phase of the nursing process; they had very restricted inputs to the phases of assessment, planning and evaluation.

This example illustrates the general conclusions reached in this study concerning context - that the manner in which nursing was conducted and hence the opportunities to display and observe particular competencies varied substantially from one context to another, that the actual nursing performance of the graduates was significantly influenced by their immediate nursing context, and that there was a lack of consistency between the criterion statement (the Nurses Board Statement of Competencies) and the manner in which nursing was actually practised in particular contexts.

While a detailed study of the contexts was not an initial aim of the project, to justify the above conclusions, the following sections provide descriptions of the manner in which nursing care was carried out in each of the five role areas of the criterion statement. It must be stressed that this is a post-hoc analysis, based on information drawn from several sources: interviews with the supervisors providing ratings, interviews with the graduates, from sections of the NPRF and from comments provided when the NPRF ratings were made.

It is also important to emphasise that in providing these descriptions, no judgements are made concerning the desirability of any particular approach to nursing care or of the criterion statement; the discussion which follows aims to be entirely descriptive and not evaluative. The descriptions relate to ten separate contexts in which graduates were evaluated, in four Perth metropolitan hospitals.

5.3 HEALTH TEACHING ROLE

In the NPRF data, supervisors indicated that health teaching occurred in each of the contexts in which graduates were assessed, and it was generally considered to be an important part of the role of a registered nurse. At the same time, while 67% of hospital-trained graduates indicated that they frequently acted in the role of health teacher, only 38% of WAIT graduates did so.

This area of nursing performance is probably the most difficult to evaluate, either through the use of trained observers or through supervisor ratings. Difficulties arise for three reasons. Firstly, in the contexts in which the graduates studied were working, health teaching consisted of a one-to-one interaction between nurse and patient, in which many of the component processes occurred in the minds of the patient or the nurse and were unobservable, or led to outcomes which may not be directly observable, or may not have been evident for some time.

Secondly, it is likely that varying interpretations of health teaching were being used, both by graduates and by supervisors. This may account for the disparity in responses between WAIT and hospital graduates mentioned above, in that WAIT graduates may have been utilizing a definition of health teaching more consistent with that in the Nurses Board Statement of Competencies. The health teaching role can be considered at three levels. The first involves the provision of information concerning what is or will be happening to the patient. Items

in the descriptive schedule of the NPI fall into this category, for example, "Patient provided with basic hospital information", and "Patient informed about what is happening or about to happen, and his/her role in the activity". The second level consists of non-intentional teaching which may often be patient initiated or facilitated whereby, for example, in response to questions from the patient, the nurse provides information or explanations as is required. The Health Education scale of the NPI is predominately made up of activities at these first two levels. The third level, which is the main focus of the Nurses Board Statement, involves a deliberate process of nurse initiated teaching involving an assessment of the patient's needs for teaching and his or her existing level of knowledge, and the resulting systematic planning and conduct of the teaching activity. These components were reflected in the design of the NPRF. However, it was apparent that a number of the supervisors understood teaching at the first two levels and rated graduates accordingly. In part, this may have occurred because systematic teaching plans are generally not documented, and "evidence" of whether the problem-solving approach was being used was therefore not available.

A third factor which hampers the evaluation of the health teaching performance of any one nurse is the lack of clearly defined roles in relation to health teaching. In task-oriented nursing situations, the task of teaching a patient does not appear to be allocated along with the other tasks for the day. Hence, it is difficult to disentangle (and hence evaluate) the contribution of any one nurse to a patient's health education.

It was apparent that there were relationships between the manner in which nursing care was organised in the ward and the form of health education, although insufficient data were available to enable these relationships to be made explicit.

5.4 PROVIDER OF CARE ROLE

This area of nursing performance consists of four phases: the assessment, planning, implementation and evaluation of care. To the extent to which it is possible, given the nature of the data from which conclusions have been drawn, an attempt has been made to examine the ways in which the nursing process is fragmented. This fragmentation may arise from :

- a) the opportunities the nurse, and in particular the recent graduate, has to perform at each phase of the process, and
- b) the amount of nursing responsibility that is shared at each phase and across the entire process for any given patient.

In order to explore the nurse's role in each context for this area of nursing performance, the following questions were asked of the data. Many of the questions are difficult to answer from the information sources used in this study; they do, however, provide a reasonable framework for establishing the nature of the role of the nurse in the contexts in which the graduate nurses were working.

Assessment of Patient Needs

1. Who makes the initial assessment of the patient on admission to the ward?
2. What types of information are gathered, and from what sources, in making an assessment?
3. Is this information documented; by whom and how?
4. Who carries out ongoing assessments of the patient's needs?
5. Where is this information documented and by whom?
6. What is the specific role of the nurse being evaluated?
Does this vary between shifts?

Planning of Care

1. Does the nurse who assesses the patient's needs also plan to meet those needs? If not, who plans the nursing care?
2. Is the care plan documented; if so, when, where and by whom?
3. To what extent does the care plan deviate from a total patient care model?
4. To what extent do ward routines and doctors' standing orders influence care planning?
5. Is there evidence of the utilisation of a problem-solving approach in care planning?
6. What is the specific role of the nurse being evaluated in connection with the planning of care? Does this vary between shifts?

Implementation of Care

1. Does the nurse who plans care also implement that care of the patient?
2. How are nursing staff organized to work with regard to implementing care? (task oriented; team nursing; patient allocation?). How does this vary within the same context between shifts?
3. On any given shift, how many nurses (and of what level of training) are implementing care for any given patient?
4. To what extent is it ward policy to vary the tasks and/or patients assigned to a nurse from day to day?
5. In connection with this phase of the nursing process, what is the specific role of the nurse being evaluated? Does this vary between shifts?

Evaluation of Care

1. Who is responsible for evaluating the care given to the patient? For example, is it the nurse who originally planned care, or does the nurse who implements care provide feedback to the original planner, or does the nurse who implements the care also evaluate its effectiveness?

2. For any specific patient, how many nurses would usually be involved in evaluating the care?
3. Are particular nurses assigned to evaluate specific aspects of care? For example, does one nurse or team of nurses specifically evaluate wounds on a surgical ward?
4. Is information concerning the evaluation of care documented?
5. Is care evaluated in terms of stated criteria? Are these criteria documented?
6. What is the role of the nurse being evaluated with regard to this phase? Does this role vary between shifts?

5.4.1 The Assessment of Patients' Needs

(a) Initial assessment of the patient.

The nurses evaluated in this study all carried out some form of initial assessment of patients, although their role in this area was quite variable from one context to another.

Three main variations occurred. In one approach, in which the organization of patient care consisted of a combination of task and patient allocation systems, within teams, responsibility for assessments varied. However, since a considerable degree of nurse autonomy and individual responsibility prevailed all nurses (including those evaluated) carried out regular assessments, which could be readily evaluated as detailed documentation was available.

The second approach was associated with the use of nursing teams in which work was largely or wholly task oriented. The nurse admitting the patient first completed a set of standard items on a ward admission sheet. Then, under the task allocation system, the task of assessing new patients was

assigned to a member of the team. As task allocations varied, all nurses were involved in assessments. However, due to a tendency towards the centralised control of nursing staff in these contexts, the team leader and/or the charge nurse often had considerable involvement.

In the third approach, which involved patient allocation, the nurse to whom a patient was assigned conducted the assessment.

(b) Form and documentation of assessments.

Again, three main approaches were observable. The standard procedure in one context involved the systematic assembling of information relating to the patient's medical and surgical history, present health problems and understanding and feelings about these, socio-economic status and history, religious needs, daily habits and nursing observations. This information was documented in a standard way.

In several other contexts a similar, although considerably less comprehensive, assessment was conducted at the time of admission, which involved the collection of standard information from the patient and other sources.

In the majority of contexts it appeared that assessments were not standardised and, in general, were not documented. In these cases it was usual for assessments to be translated immediately into task-oriented care plans.

c) Ongoing assessments.

In general, the care of patients was dispersed among nursing staff such that it was unlikely that one person would be primarily responsible for initial

and ongoing assessments. It was more usual for several nurses to be involved in making ongoing assessments. The documentation of these was generally contained (either explicitly or implicitly) in reports on current patient status or revisions of nursing care plans, which were often prepared by a person other than the nurse making the assessments.

In summary there was substantial variation between contexts concerning the manner of, and responsibility for, patient assessment. In some cases this variation occurred within wards from one shift to another. In general terms, the responsibility for initial and ongoing assessments was dispersed, and documented in varying ways. As a result it was difficult for supervisors/observers to ascertain the performance of the recent graduates against criteria derived from the Nurses Board Statement of Competencies.

5.4.2 The Planning of Care

The information obtained from the NPRF and the interviews with supervisors and graduate nurses indicated that considerable variation existed in the ten different contexts with regard to this phase of the nursing process. The variation in the way in which the planning of care occurred is illustrated in Table 5.1.

In three of the ten contexts (1, 2, & 3) no formal care plans existed; nursing notes and verbal information provided the basis for nursing intervention. In addition, for two other contexts (9 and 10) it was doubtful whether formal plans were used. In these, observance of the standard care

Table 5.1 Planning of care within nursing contexts

QUESTIONS	NURSING CONTEXTS							
	1,2,3	4	5	6	7	8	9	10
1. Do formal care plans exist?	No	Yes	Yes	Yes	Yes	Yes	Doubtful	Doubtful
2. What form do care plans take?	Nursing notes	Comprehensive standard document	←		Standard Cards	→		Standard Care Sheets; Treatment book & notes
3. What do care plans cover	Patient Status Procedures	Procedures, Instructions, Goals, Discharge planning; outcomes	←		Diagnosis Procedures, Preparations, Hygiene needs	→		Check list of tasks and procedures
4. Who formulates care plans?	Charge Nurse	Nurse who does Assessment	Nurse assigned to patient	←		Nurse in Section to which patient admitted	Nurse assigned to patient	Charge Nurse
5. What information is documented? Sources?	As on admissions sheet	Complete history & up-dating of plans	←		History, (No updating of pm shift)	→		Treatment Notes
6. What factors mediate in planning of care?	Ward routine Policy, Doctors orders	Ward routine, Doctors orders	←		Ward routine Doctors orders Charge Nurse	→		Routine Ward Management
7. What is the role of the junior nurse?	Very limited; Make suggestions as ward team member	Major involvement (often on a shared basis)	←		Have opportunities; Initiatives restricted	→		Opportunities to modify/up-date plans. Restricted opportunities to show initiatives.

sheets was made redundant by the use of treatment books and comprehensive verbal information passed on at hand-over times. Planning in these five contexts appeared to be largely task-oriented.

In the five contexts (4 to 8) where care plans did exist, these were usually in the form of checklists. The potential for using these as a basis for problem-solving within a total patient care model as indicated by the Nurses Board Statement of Competencies, seemed limited. In only three of these contexts (4, 5 and 8) did the standard plan formats offer scope for problem-solving and total patient care. However, comments by supervisors and graduates indicated they tended not to be used in this manner.

The data also suggest that the graduate nurse did not have many opportunities for assuming major responsibility for the planning of care. In most of the contexts the constraints which prevailed (for example, in terms of charge nurse preferences, ward management and routines), were such that the individual nurse generally had limited opportunities to demonstrate initiative and autonomy in formulating care plans.

In summary, the involvement of junior nurses in formulating care plans differed between contexts from having little or no involvement to the formulation of quite detailed plans for care based on the nurse's own assessment of patient needs.

Table 5.2 summarizes the relationships between the assessment and planning phases in terms of the individuals involved.

Table 5.2: Relationships between planning and assessment phases

CONTEXT ↓	INVOLVEMENT OF RECENT GRADUATES		
	Assesses patient needs & translates these into plans	Assesses patient needs but planning carried out by someone else	Updates care plans
1		*	
2		*	
3		*	
4	*		*
5	*		*
6	*		*
7	*		*
8	*		*
9		?	
10		?	

5.4.3 The Implementation of Care

For the nurses evaluated in this study, especially those in their first year post - registration, the implementation of care was their main sphere of activity. Accordingly, the use of the NPI was particularly appropriate, since its focus is almost exclusively on this phase of the nursing process.

There appeared to be little continuity between the planning and implementation phases of the nursing process when the responsibilities of a single recent

graduate were considered. The continuity of contact any nurse had with a patient in implementing care was determined by the organization of patient care on the ward, that is, by the way in which tasks and/or patients were allocated. The majority of contexts examined were such that nursing staff were divided into teams, containing both registered and, in the case of teaching hospitals, student nurses. Within teams, the implementation of care was assigned to nurses either by way of tasks, (for example, bedmaking, showers, dressings), or by patients, such that an individual nurse was responsible for all the care given to a number of specified patients. Under other arrangements, individual nurses were allocated a number of patients and did not work in teams. Additionally, an arrangement prevailed in one context whereby individual patient allocation occurred for morning shifts, while task-oriented team nursing occurred on afternoon and night shifts.

From the perspective of an evaluation study of nursing performance, some of these arrangements created difficulties for supervisors in ascertaining the specific contributions of any particular nurse, especially where the organization of work was such that more than one nurse could be responsible for the care of a patient.

Fragmentation of nursing responsibility was evident at this phase of the nursing process. Even if the assessment and planning of care were the primary responsibility of a particular nurse, the opportunities that nurse had to follow plans through and to monitor their effectiveness were limited when the responsibility for care was divided between a

number of nurses. Similarly, where a patient allocation system prevailed it was often customary to change the patients allocated to a nurse from day to day.

5.4.4 The Evaluation of Care

As was mentioned in connection with the implementation phase, the fragmentation of responsibility for care of a given patient often did not allow for close monitoring of the outcomes of nursing intervention and the re-appraisal of care plans.

This was especially evident where criteria for assessing the outcomes of nursing intervention were not specified and documented, and where a number of nurses were involved in working with a single patient.

It has not been possible to discern from the data the exact processes of evaluation in any given context, nor the role of the graduate nurse in this respect.

5.5 CO-ORDINATOR OF CARE ROLE

The data from this study demonstrate that the Co-ordinator of Care role may manifest itself in the following spheres of activity :

- (a) Co-ordinating the care of patients for whom the nurse is responsible. This may occur in two ways:

- (i) When the nurse is in charge of a section of the ward as team leader, she is responsible for co-ordinating the care of patients within that section. In particular, the nurse would be required to co-ordinate or supervise the activities of other team members and to liaise with the charge sister and with other health team members. The nurse might also be required to consult with the patient's relatives, especially when they are actively involved in caring for the patient.
 - (ii) When the nurse has been allocated patients for whom she alone is to provide care, coordination of her own activities in order to meet the patient's needs, is necessary. This may involve liaising with other nursing staff and, in particular, with the charge sister as well as with other members of the health team. The nurse's involvement with the patient's relatives is the same as in (i) above.
- (b) Co-ordination of patient care and ward activities when the nurse is in charge of the ward.

This involves co-ordinating the activities of other nursing staff by delegating responsibilities and ensuring that these are followed through. This role requires liaison with the patient's relatives, other members of the health team, clerical or administrative staff and the various departments within the hospital (for example, X-ray, pathology, blood bank, catering services).

- (c) Arranging for the continuing care of patients after discharge, through liaison with the patient's relatives or other health team members.

Table 5.2 summarises the spheres of activity in the Co-ordinator Role for the recent graduates working in the ten contexts examined in this study. The table demonstrates the variations in role from one context to another, and shows that for some components of the role, opportunities to demonstrate specific competencies were either never available or only occasionally so.

Table 5.3 Spheres of activity of the recent graduates in the co-ordinator role in the ten contexts.

CO-ORDINATOR	FREQUENTLY	OCCASIONALLY	NEVER
a) (i) As a team leader	7	2	1
(ii) Co-ordinating the care of allocated patients	3	4	3
b) When in charge of the ward		7	3
c) Arranging for continuing care of patients		3	6

5.6 THE COMMUNICATOR ROLE

It is important to begin the discussion of this role by stating that the kinds of communication skills the nurse is required to use within a particular context are determined by the ways in which the four other nursing roles are operative in that context.

For example, as a Provider of Care, the nurse may be involved in the assessment of patients' needs, the planning required to meet these needs, the implementation of nursing care, and the evaluation of the outcomes of care. At each of these phases it is necessary for the nurse to utilize a number of specific

communication skills, which depend on the manner in which each phase is conducted in that context. Thus the skills in communication required in one context at any phase may not be the same as in another. This is true for each of the other three nursing roles, that is, Co-ordinator, Health Teacher and Member of the Profession.

If, for instance, the nurse is required to make a full assessment of the patient's physiological, psychological and social needs, then interviewing skills are necessary and the degree of competence may be observed and assessed. In a context where the concentration is largely on the patient's physiological needs, this is not the case.

The same dependence on context applies to the area of written communications. For example, in some contexts written care plans consist primarily of check lists, while in others, more elaborate written plans which specify objectives for patient care are required.

The NPRF attempted to evaluate what could be described as the "lowest common denominator" in communication skills, that is, those related to verbal, written and non-verbal communications which are applicable across all situations. However, in so doing the instrument may fail to directly assess some of the more specialised communication skills required in certain contexts (for example, interviewing skills), and as a result is unlikely to properly discriminate between different levels of performance in the communication area.

5.7 MEMBER OF THE PROFESSION ROLE

The treatment of this role area in the NPRF is reasonably detailed and is generally applicable across contexts. It should therefore elicit meaningful information regarding individual performance in this role.

However, the effect of context occurs in another way: ratings of this role may be strongly influenced by the values of the evaluator and the ethos of the hospital in which the nurse is working. For example, a nurse who accepts the expectations of the ward may be regarded as an outstanding member of the profession whereas another who is a vocal or active in advocating change in order to improve patient care may not be so highly regarded. It would seem that the supervisor's evaluation of nursing performance in this role is most open to personal or institutional biases.

5.8 CONCLUSIONS REGARDING IMMEDIATE NURSING CONTEXT

In general terms, the following conclusions are drawn concerning the effects of context:

- a) that the manner in which nursing was conducted, and hence the opportunities to display and observe particular competencies varied substantially from one context to another,
- b) that the actual nursing performance of the graduates was significantly influenced by the immediate nursing context, and
- c) that there was a lack of consistency between the criterion statement (the Nurses Board Statement of Competencies) and the manner in which nursing was actually practised in particular contexts.

In part, these findings are the result of the process of professional socialization, which is discussed in more detail in the following section.

5.9 NURSING CONTEXTS AND THEIR INFLUENCE ON OCCUPATIONAL SOCIALIZATION

Some of the issues associated with the preparation of professionals in any field are related to professional or occupational socialization. The process of socialization can be defined as the mechanism by which neophytes are inducted into the culture of their chosen group. On entry into actual work settings, professional personnel tend to feel a strong need to comply with the values and norms of their reference group, in their efforts to identify and gain group membership. In the case of the nurse, socialization influences include experiences through which the new member learns, in a concrete fashion, what a registered nurse does, what constitutes desirable or acceptable behaviour, and what norms attach to the behaviours and actions a nurse displays in her daily role.

Since the learning of new roles and adjustment to the adopted profession is facilitated primarily through social interaction, it is important that the variable of "work settings", or "nursing contexts" in which the interaction occurs be examined more closely.

In the sections which follow, information drawn from interviews with the supervisors and the graduates is used to examine and illustrate the socialization influences of the context in which the graduates were working.

5.9.1 Expectations of the WAIT Graduates

Using data from the interviews, it has been possible to gauge how beginning nurses perceived their working environments, and also what observations were made by supervisory staff of the graduate nurse's "fit" into the world of work. Initially, a group of fifteen WAIT graduates were interviewed on exit from their course (December, 1980). In the follow-up interviews,

(December, 1981) only 8 nurses from the original sample were available. The interview questions focused on the nurse's expectations and concerns, as well as her assessment of her own skills, knowledge and preparation.

In the initial interviews, responses to the question: "What are you looking forward to?" clustered around four distinct expectations. These were: gaining confidence, gaining experience, taking responsibility for nursing initiatives and decisions, and patient contact.

Despite the broad nature of these expectations, many of the graduates were ambivalent, when asked in the follow-up interviews how well these had been realized. Most indicated they had gained the confidence they had expected. Regarding experience, more than half the group felt they would have liked more experience in specialized areas (for example, surgical). Reservations were also expressed about the extent to which nursing contexts provided for total patient care. Furthermore, at least half the group felt that opportunities for assuming responsibility were restricted. Some of their comments (see below) suggest, perhaps, that the first year's experience might not have been too positive or encouraging.

"I have confidence with patients, but I'm still lacking in confidence with doctors and relatives."

"I can recommend things, but there's not much opportunity to initiate things myself."

Respondents often indicated that charge sisters were reluctant to share or delegate responsibilities, and that they tended to follow set procedures and routines and were not amenable to change.

As regards their anticipated concerns and apprehensions, it would appear that most personal fears were unfounded. No specific problems with regard to unfamiliarity or settling in

were experienced, and fears were not as bad as initially anticipated. Most graduates felt comfortable with the way in which they had executed various tasks and procedures and believed that they had also successfully acquired skills in communication. While the attitudes of nursing colleagues appeared to be reasonably positive, some graduates reported they still felt uncomfortable in the presence of some medical staff.

5.9.2 Interviews with supervisors

Interviews with supervisors were conducted on the wards, with each session lasting between 15 and 45 minutes. Table 5.4 summarises the supervisors' responses to the first interview question.

Table 5.4 Summary of responses to Question 1
"Would you keep the nurse on your ward?"

	Attitudes	Nursing Performance
WAIT GRADUATES	• mature • reliable • well-adjusted • shows concern for patients	• attention to safety and legal aspects • thorough understanding of psycho-social aspects of care • good team member • requires little supervision
HOSPITAL GRADUATES	• reliable • keen • supports staff	• is effective and thorough • works quickly, but.. • asks seniors when in doubt • good at reporting what goes on

The few negative comments referred to personality differences and characteristics, lack of involvement and unreliability, and related to both groups of graduates.

Table 5.5 Summary of responses to Question 2
"Strengths in nursing performance"

	Attitudes	Nursing Performance
WAIT GRADUATES	● professional manner ● caring approach ● empathy ● confident ● reliable ● mature ● liked by patients ● doesn't 'rock the boat'	● skilful at report-writing and procedures ○ efficient/thorough ● good rapport with patients and relatives ● strong theoretical background ● good communication skills
HOSPITAL GRADUATES	● thorough ● reliable ● co-operative team member ● caring	● technical expertise ● good communication skills ● good rapport with patients ● leadership qualities ● copes well with workload

Judging from the comments, there would seem to be very little which obviously differentiated the WAIT group from the hospital group, in terms of nursing strengths as perceived by supervisors. Furthermore, if anything came through strongly and consistently, it was the perception that both groups had commendable skills in communication.

Table 5.6 Summary of responses to Question 3:
"In what areas is improvement needed?"

	Attitudes	Nursing Performance
WAIT GRADUATES	● manner too abrupt ● dogmatic: does not compromise ● unpredictable	● not good as team nurse ● ward experience: does not work effectively under pressure ● lags behind: too involved in talking to patients
HOSPITAL GRADUATES		● lacks confidence ● written communication ● teaching ability ● too involved with patients: talks too much ● coping with relatives ● needs to be more decisive

A common perception of supervisors was that beginning nurses lacked confidence in their own ability, and in making decisions. More experience was required in learning how to co-ordinate nursing care.

Table 5.7 Summary of responses to Question 4:
"Did the nurse come fully equipped to handle nursing on your ward?"

	Attitudes	Nursing Performance
WAIT GRADUATES	● more aware that mistakes could be made; therefore, more anxious and afraid ● more cautious, because of lack of experience	● needed less supervision (contrary to expectation) <u>but</u>: lacked experience to handle specialised areas
HOSPITAL GRADUATES	● not enough self-confidence; therefore unsure, and unable to make decisions	● competent at general, basic nursing, <u>but</u>: lacked ability to handle specialised area ● had to adapt and learn ward routines ● lacked ability to make decisions

Table 5.8 Supervisors' responses to interview questions

Interview question	Supervisors of WAIT graduates (n = 16)	Supervisors of Hospital graduates (n = 26)
Question 1		
"Would you keep this nurse on your ward?"		
Yes	14	22
No	2	4
Question 4		
"Do you feel this nurse came to your ward fully equipped to handle nursing?"		
Yes	10	16
No	6	10
Question 7		
"Does this nursing environment inhibit this nurse's potential performance?"		
Yes	6	6
No	10	20

For questions 1 - 4 (see Appendix 5 for copy of interview schedules) responses fell into two groups, namely, attitudes and nursing performance. In view of the qualitative nature of the data, only the most frequently mentioned comments have been summarised and presented to reflect the views expressed by the supervisors.

While supervisors agreed that most of the beginning nurses were competent in basic nursing skills, the two areas cited in which they lacked competence were:

- (i) specific skills required in specialised areas of nursing (for example, a renal unit; orthopaedics), and
- (ii) taking charge or assuming greater responsibility for decision-making, as is required of a registered nurse.

In response to question 7: "Does this nursing environment inhibit this nurse's potential performance?" most supervisors replied "no". (See Table 5.8.)

However, those who suggested the environment was inhibiting, made the following observations:

- Students were not involved in total patient care planning
- Nursing was task-oriented
- There were no opportunities for taking responsibilities
- There were no opportunities given to show initiative.

The inhibiting nature of the working environment could be summed up in the words of one charge sister who observed that there was some disjunction between the approach and orientation emphasized in the college nurses' course of training, and the demands and realities of the work setting:

"She is inhibited by the task orientation of the ward. She doesn't have the opportunity to employ the nursing process. She would, therefore, be less inhibited in a primary nursing area."

Those who did not perceive the environment to be inhibiting, made the following observations:

"No, she is a junior nurse and knows her place."

"No, nurses on this ward have every opportunity to make their own decisions regarding nursing care."

"No, the nurses have to adapt to the environment in which they are working."

Much of the information derived from interviews, with both supervisors and nurses, lent support to findings from recent and relevant research. Kramer (1974) referred to the phenomenon of "reality shock", experienced by new graduate nurses as they adjusted to the bureaucratic structures of hospital work settings.

Other studies, such as the Canadian Ryerson study (Allen and Reidy, 1971) and the Victorian studies (Mackay, Brooke and Bruni, 1981; McArthur, Brooke and Bruni, 1981) have also explored the variable of context, and presented some evidence concerning the importance of such concepts or organizational climate, nursing environments and adaptive behaviours of beginning nurses. In the Ryerson Study, the process of professional socialization was viewed in terms of "fit" into the work world. When interpreted as a process of conforming to traditional routines and well established norms and customs, the concept of "fit" was seen to be a moulding process, one of deliberately shaping the newcomer to accept the prevailing "custom". On the other hand, Allen and Reidy (1971) also suggested that the concept of "fit" could be regarded as an internally perceived need by the nurse graduate to adjust and to adapt, rather than as an externally imposed demand to conform. In this case the young professionals are judged by others in the profession against an ability to adapt, a readiness and flexibility to respond to changing needs and demands, and a display of behaviour appropriate to the situation in the system.

5.9.3 Graduate Nurse Self-Assessment Interview Data

The self-assessment information was obtained in interviews with both groups of graduates in response to essentially the same questions asked of supervisors. On analysis, the interview data revealed some differences between the two groups of nurses of their perceptions of their own strengths and weaknesses. More important, however, is the consistency with which both groups have been equally critical of the environments in which they were working.

Regarding strengths in nursing performance, WAIT graduates were more analytical and perceptive in their replies than the hospital nurses. Most commonly cited by both groups were strengths related to inter-personal skills and communication. While several hospital graduates regarded practical nursing

skills and procedures as their particular strengths, these were not singled out by the WAIT graduates. More WAIT graduates than hospital graduates gave knowledge-related behaviours as their strengths (for example, keeping themselves informed, keeping patients informed, teaching patients and students.)

Referring to perceived weaknesses, both groups indicated that these were in the areas of ward organization and administration, and provision of emotional support to patients and relatives. Differences between the two groups did, however, emerge with respect to one aspect of their competencies. While several hospital nurses claimed they were lacking in knowledge and felt they were functioning from a limited theoretical base, this was not mentioned by any of the WAIT graduates as an area requiring improvement. On the contrary, the most commonly-felt need expressed by the WAIT group was a need for experience and the opportunity to put theory into practice. The following are illustrative of responses received during the interviews:

WAIT GRADUATES

"There are practical skills that I don't know yet - I haven't encountered them yet."

"Procedures, and working the system."

"There are certain things I've never seen or done. My practical skills are lacking in some areas".

HOSPITAL GRADUATES:

"Theory"

"I lack knowledge"

"Basic knowledge"

"Theoretical knowledge, for example, mental disorders, diseases."

"Psychology - need more education in this field."

Two questions which produced detailed descriptive (and critical) observations from both groups of nurses were Question 1 ("Would you be happy to continue working on this ward, given the opportunity?") and Question 7: ("Do you feel that this nursing environment in any way inhibits your potential performance?").

Question 1 elicited the concerns which nurses consider important in their work environment - the satisfactions, the rewards, the influences. There were no obvious differences between the responses of the two groups. The opportunity to learn and broaden experience was the most frequently cited desirable feature of a work setting. Another frequently mentioned factor was ward atmosphere and staff relations, which, it was claimed, was greatly influenced by the attitudes, values and orientations to ward management of the charge sister.

Question 7 provoked an equally vocal response from practically all the nurses, even though they tended to talk about what they did not like in their work environment rather than identify the factors that actually inhibited their performance. Analysis of the responses to this question indicated the following :

- i) Of the 21 nurses, only three (two hospital-trained and one WAIT-trained) claimed they were not inhibited by their environment.
- ii) Initially all WAIT nurses felt frustrated by some of the attitudes and thinking (or lack of it) encountered in their hospitals. According to them, there was a tendency to follow routines instead of working from first principles. Staff appeared to lack enthusiasm for accepting new suggestions. By contrast, except for one nurse, there were no comments from hospital nurses in this regard. Typical of the observations of WAIT, nurses were the following:

"Nursing staff appear to do things simply because it is a rule."

"Lack of opportunity for flexibility; things are done the charge sister's way and she is not very open to change."

"There are lot of hospital and ward policies which are not right and which I cannot go along with."

"I feel frustrated by some of the things they do. The hospital trained staff are more accepting - they won't rock the boat in case there might be repercussions."

"I would have been able to perform better had I been working in primary nursing with a different charge sister."

"The upper levels of the hierarchy on this ward are inhibiting. They are not willing to help much."

- iii) Hospital nurses were more likely to point the lack of staff and equipment as inhibiting the standard of patient care they were able to provide. Typical of their responses were the following:

"The building is old-fashioned and dilapidated. There is a lack of equipment."

"The equipment is inadequate - limited stock."

"There is a lack of staff on some days which means that you don't have the time to give patients."

"I feel frustrated by the slack atmosphere. There is too much friendliness at all levels."

- iv) Both groups felt restricted in not being allowed to assume responsibility (for example, going on rounds with the doctor; being in charge of a ward).

5.10 SUMMARY : CONTEXTS AND SOCIALIZATION

It is apparent, from the information obtained through the interviews with supervisory staff and the graduates, how important nursing contexts are in shaping the perceptions, attitudes and behaviours of beginning nurses. It is suggested that the contributions from the present study serve to highlight issues that have emerged from previous research.

Data from the interviews point to both formal and informal processes of socialization which the beginning nurse encounters in her work environment. The formal processes appear to be reflected in the procedures by which the beginning nurse is admitted to the work setting. Initially, through orientation activities, the beginning nurse is guided through the prevailing organizational structure and its associated hierarchy. Once she has moved into the routines and patterns of the work setting, the nurse comes under a powerful informal influence via daily contacts with role models. Here the influence of colleagues (both peers and supervisors) becomes important in translating into practical realities the demands of "the system" for the beginning nurse to accept and adopt.

The research literature on professional socialization suggests that there may be a distinct relationship between the socialization process and the concerns of the beginning nurse. The relationships may be expressed as a three-stage programme. First, there is concern for SELF, with a focus on survival, on a need to identify, and on the desire to be accepted. This is followed by a concern with TASKS, where the focus is on mastery of routines and procedures, in order to cope with established practice, time and workload pressures, and organizational constraints. The justification for such a focus would seem clear: it becomes a necessity for allaying fears of inadequacy, and for gaining acceptance by others. Finally, once she has established herself within the system, the nurse might begin to show concern for the IMPACT of what she does, paying attention to patient needs, and tailoring routines and procedures to what needs to be done (as opposed to how it is to be done).

From the present study, it is not possible to postulate exactly how far along this three-stage progression either group of beginning nurses had gone by the end of their first year. There certainly appeared to be some indication of conformity to and acceptance of the prevailing norms and customs (and, perhaps more so in the case of hospital nurses). By the same token, both

groups also appeared to show a questioning attitude, which was reflected in their critical appraisals of their nursing environments during the interviews. What is missing from the data gathered on nursing contexts, however, are actual instances of the kinds of influences beginning nurses are prepared to exert in work settings, and the ways they set about changing attitudes and behaviours of their colleagues.

The numbers in this study have been small. It would therefore be inappropriate to draw any definitive answers or conclusions from the interview data. On the other hand, some issues have emerged, or have been hinted at, which point to the desirability of taking serious account of nursing contexts in evaluating the performance of newly graduated nurses. Specific suggestions for further research in this area are made in Chapter 7.

CHAPTER 6

RESULTS: PERFORMANCE RATINGS

In this chapter the performance rating results are presented in two main sections. Section A relates to findings based on NPI data and Section B to findings based on NPRF data. It is emphasised that these results need to be considered in the light of the discussion presented in Chapter 5 on nursing contexts.

A.OBSERVER RATINGS OF PERFORMANCE

6.1 NPI RATINGS

On each of the 14 evaluative scales of the NPI, the mean ratings of the performance of the two groups of graduate nurses were virtually the same. The data are displayed in Table 6.1.

For all but one evaluative dimension, differences between the mean ratings for the two groups were not statistically significant. There was a significant difference in the mean ratings assigned for "efficiency"; WAIT graduates scored significantly higher (mean = 3.12) than did their hospital counterparts (mean = 2.97). This difference is significant at the 0.05 level.

6.2 RANKING OF AREAS OF NURSING PERFORMANCE

Table 6.2 shows the rank order of ratings for the two graduate groups, on the 14 evaluative dimensions. A rank order correlation revealed no significant difference, overall, between the performance of the WAIT and hospital graduates.

Both groups of graduates scored highest on the same evaluative dimension ("concern", a component of the Interpersonal Skills area), and lowest on the same dimension ("Safety", a component of the Technical Skills area). There was no significant difference between these ratings for the WAIT and hospital graduates.

Table 6.1 Means for the 14 evaluative dimensions of the NPI

Evaluative Dimension	Wait Graduates Mean Ratings (n = 8)	Hospital Graduates Mean Ratings (n = 13)
1. Skill with interpersonal relationships	3.02	3.04
2. Skill with procedures	2.99	2.87
3. Ability to provide individualised nursing care	3.07	2.96
4. Organisational ability	3.12	3.00
5. Professional competence	3.03	2.97
6. Health education	2.97	2.95
7. Safety	2.91	2.82
8. Confidence	3.12	3.00
9. Sensitivity	3.12	3.13
10. Concern	3.29	3.19
11. Speed	3.06	3.04
12. Comfort	2.94	2.98
13. Efficiency	3.12	2.97
14. Co-operating as a member of the health team	3.06	3.12

Table 6.2 Means and rank order of observer mean scores on the NPI, for WAIT and hospital graduates.

Evaluative Dimension	WAIT Graduates		Hospital Graduates	
	Mean	Rank	Mean	Rank
10. Concern	3.29	1	3.19	1
4. Organisational ability	3.12	3.5	3.00	7
8. Confidence	3.12	3.5	3.09	4
9. Sensitivity	3.12	3.5	3.13	2
13. Efficiency	3.12	3.5	2.97	9.5
3. Ability to pro- vide individual- ised nursing care	3.07	6	2.96	11
11. Speed	3.06	7.5	3.04	5.5
14. Co-operating as a member of the health team	3.06	7.5	3.12	3
5. Professional competence	3.03	9	2.97	9.5
1. Skill with inter- personal re- lationships	3.02	10	3.04	5.5
2. Skill with procedures	2.99	11	2.87	13
6 Health education	2.97	12	2.95	12
12. Comfort	2.94	13	2.98	8
7 Safety	2.91	14	2.82	14

The range of scores for the two groups was virtually the same, as can be seen from Table 6.3

Table 6.3 Range of mean observer scores on NPI evaluative dimensions.

	Highest Mean Score	Lowest Mean Score	Range
WAIT Graduates	3.29	2.91	0.38
Hospital Graduates	3.19	2.82	0.37

6.3 INTER-RATER AGREEMENT

The confidence that could be placed in the observer data derived from the NPI can be seen from Table 6.4 which demonstrates the extent of inter-rater agreement on each of the 14 evaluative dimensions. It can be seen from the table that for most areas substantial inter-rater agreement occurred, that is, raters were either in perfect agreement, or provided ratings different by 0.1 - 0.2 scale points. Their level of agreement was particularly noticeable for the dimensions of professional competence, organisational ability, efficiency, skill with procedures, sensitivity and speed. However, in some areas (for example, health education, safety, confidence and skill in interpersonal relationships), the extent of inter-rater agreement was somewhat reduced.

6.4 LEVELS OF PERFORMANCE

As in the Victorian study, the performance ratings of the WAIT and hospital graduates were grouped into three categories:

highly acceptable, acceptable, and unacceptable. It is pointed out that these categories are arbitrary, being dependent on the values and standards transmitted through the observer training programme, and could be further influenced by the personal values of the observers. Table 6.5 sets out the comparative ratings for WAIT and hospitals graduates, showing which areas were rated similarly, and differently, for the two groups. For neither group did the ratings, on any area of nursing performance, fall into the unacceptable category. (Mean ratings of 3.0 and above were used to determine the "highly acceptable" category, and mean ratings of between 2.0 and 2.9 to determine the "acceptable" category).

Of the 14 evaluative dimensions, there were 10 for the WAIT group and 7 for the hospital group that were rated "highly acceptable". The dimensions of efficiency, ability to provide individualised nursing care and professional competence were rated "highly acceptable" for the WAIT group while for the hospital group these were rated "acceptable". For both groups the four dimensions of skill with procedures, health education, comfort and safety were rated "acceptable".

In summary, on the basis of the NPI data for the limited numbers of graduates available for study, no significant difference was observed in the performance of the WAIT group and the hospital group.

B. SUPERVISOR AND SELF RATINGS OF PERFORMANCE

As explained in Chapter 4, the Nursing Performance Rating Form (NPRF) was used to obtain ratings by supervisors (charge nurse and second-in-charge) on a set of specific items within each of the five areas of the Nurses Board Statement of Competencies. For each item, a rating of "how consistently the nurse utilises the opportunities available to perform in the manner described" was obtained. For each role area, an overall judgement of the quality of performance in that role was also obtained, on a scale which sought to relate performance

Table 6.4 Inter-rater agreement on NPI

Evaluative Dimensions	Magnitude of differences between mean rater scores for 26 observed graduates					
	0	0.1 to 0.2	(n ₁)	0.3 to 0.4	≤ 0.5	(n ₂)
1.Skill with interpersonal relationships	2	15	(17)	6	3	(9)
2.Skill with procedures	9	10	(19)	5	2	(7)
3.Ability to provide individualised nursing care	5	12	(17)	5	4	(9)
4.Organisational ability	8	12	(20)	6	0	(6)
5.Professional competence	6	15	(21)	2	3	(5)
6.Health education	3	9	(12)	7	7	(14)
7.Safety	6	8	(14)	5	7	(12)
8.Confidence	7	8	(15)	7	4	(11)
9.Sensitivity	7	12	(19)	4	3	(7)
10.Concern	4	12	(16)	6	4	(10)
11.Speed	11	7	(18)	7	2	(9)
12.Comfort	5	12	(17)	7	2	(9)
13.Efficiency	7	13	(20)	4	2	(6)
14.Co-operating as a member of the health team	10	4	(14)	1	10	(11)*

* Missing data. There were no observations by one rater on this dimension. The difference between means could therefore not be calculated.

n₁ = total number of graduates for whom inter-rater agreement was high.

n₂ = total number of graduates for whom inter-rater agreement was not as high.

Table 6.5 Ranking of areas of nursing performance for WAIT and Hospital graduates.

Category	WAIT Graduates	Hospital Graduates
Highly acceptable	Concern	Concern
	Organisational ability	Sensitivity
	Confidence	Co-operating as a member of the health team
	Sensitivity	
	Efficiency	
	Ability to provide individualised nursing care	Confidence Skill with inter-personal relationships
		Speed
	Speed	Organisational ability
	Co-operating as a member of the health team	
	Professional competence	
	Skill with inter-personal relationships	
Acceptable	Skill with procedures	Comfort
	Health education	Professional competence
	Comfort	Efficiency
	Safety	Ability to provide individualised nursing care
		Health education
		Skill with procedures
		Safety

to outcomes. Finally, in the follow-up interviews, each supervisor was asked to provide a global performance rating of nursing performance, on a five point scale.

Using a modified form of the NPRF, self-assessments were also obtained from the graduates themselves.

In the discussion which follows the focus is on the overall ratings. While the ratings on specific items within roles are also of interest, the small numbers of graduates studied together with the effects of context limits our ability to draw conclusions at a detailed and specific level. The results for items within role areas are shown in Appendices 6 and 7.

6.5 RATINGS OF PERFORMANCE WITHIN ROLE AREAS : SUPERVISOR RATINGS

Each graduate was rated on a five-point scale, for each role area. Table 6.6 summarises the ratings for each group of graduates, based on the means of the two supervisor ratings for each graduate.

From these ratings it would appear that the beginning nurses as a combined group were judged by their supervisors to be displaying a fairly high level of nursing competence.

Some general comments can be made about the combined results. In the areas of Provider of Care, Communicator, and Member of the Profession, all graduates were considered to be performing at an adequate/average level or above with the proportions in the categories "outstanding/above average" and "above average/average" being similar.

In the areas of Health Teacher and Co-ordinator of Care, some graduates were considered to be performing at an inadequate level, and a smaller proportion (10% and 15% respectively) was judged to be performing at an outstanding/above average level.

Table 6.6 Mean supervisor ratings for each role area

WAIT * GRADUATES (n = 8)			HOSPITAL ** GRADUATES (n = 12)			COMBINED WAIT AND HOSPITAL GROUPS (n = 20)		
Out- standing/ above av.	Above av./ average	Below average	Out- standing/ above av.	Above av./ average	Below average	Out- standing/ above av.	Above av./ average	Below average

ROLE : HEALTH TEACHER

No.	2	5	1	1	9	2	3	14	3
%	25	63	13	8	75	17	15	70	15

ROLE : PROVIDER OF CARE

No.	5	3	0	5	7	0	10	10	0
%	63	38	0	42	58	0	50	50	0

ROLE : CO-ORDINATOR OF CARE

No.	0	7	1	2	9	1	2	16	2
%	0	88	13	17	75	8	10	80	10

ROLE : COMMUNICATOR

No.	5	3	0	7	5	0	12	8	0
%	63	38	0	58	42	0	60	40	0

ROLE : MEMBER OF THE PROFESSION

No.	5	3	0	4	8	0	9	11	0
%	63	38	0	33	67	0	45	55	0

Key: Outstanding/above average = Mean for 2 supervisors between 4.0 - 5.0

Above/average/average = Mean for 2 supervisors between 3.0 - 3.9

Below average = Mean for 2 supervisors between 1.0 - 2.9

* Based on ratings for 8 graduates. In some cases, ratings for only 7 graduates were available

** Based on ratings for 13 graduates. In some cases, ratings for only 12 graduates were available.

The below average ratings for the Co-ordinatoir of Care area could be explained by suggesting that the graduates had limited opportunities to display their skills as co-ordinators, especially in regard to co-ordinating ward activities. As a result, the lack of sufficient opportunities to develop those skills may well have impeded the development of proficiency in that area.

With regard to the Health Teacher role, the spread of ratings into the extreme categories of "noticeably above average" and "noticeably below average" would have to be explained differently. This may have arisen from differences between supervisors as to what was really meant by the Health Teacher Role.

The limited numbers mean that comparison between the WAIT and hospital groups must be made with caution. In general, there were no significant differences between the two groups. There was a slight tendency for a higher proportion of WAIT graduates to be rated above average in the areas of Provider of Care and Member of the Profession.

When the ratings for specific items within role areas were examined (Appendix 6) again no significant differences between the two groups were evident, although in some areas trends were observable.

For most specific items in the role area of Health Teacher, WAIT graduates were rated slightly more highly than hospital graduates. However, most fluctuations in ratings tended to occur similrly for both groups, possibly as a result of contextual influences. For example, all ratings for health teaching with relatives were, for both groups, substantially lower than those in relation to patients.

In the Co-ordinator of Care area there was a slight tendency for hospital graduates to be rated more highly on the specific items. For the other three role areas (Provider of Care, Communicator and Member of the Profession), ratings on specific items for the two groups were generally similar.

6.6 NPRF: INTER-RATER AGREEMENT

The extent of inter-rater agreement for the overall NPRF ratings is indicated by Table 6.7

Table 6.7 NPRF: Inter-Rater Agreement

ROLE AREA	AGREEMENT BETWEEN RATERS				
	Total Agree-	1 Point Difference	2 Points Difference	Missing Data	n
Health Teacher	11	8	1	1	21
Provider of care	10	10	0	1	21
Co-ordinator of care	8	12	0	1	21
Communicator	9	10	1	1	21
Member of the Profession	8	11	1	1	21
Overall Nursing Performance	13	6	0	2	21

This analysis shows that on 46% of the ratings, supervisors were in perfect agreement, while on 51% they differed by 1 scale point.

6.7 RATINGS OF PERFORMANCE WITHIN ROLE AREAS: SELF RATINGS

As Table 6.8 shows, the two groups of graduates rated themselves similarly for each of the role areas. For both groups, confidence in their own abilities varied between role areas. In general, the graduates were considerably more confident in the area of Provider of Care, with 60% rating themselves above average. Conversely, self-confidence in the areas of Co-ordinator of Care and Member of the Profession was considerably lower with only 25% and 20% respectively rating themselves above average. When the self ratings were compared with supervisor ratings, some interesting differences emerged, as shown in Table 6.9.

Graduates saw themselves as operating at a higher level of performance in the areas of Health Teacher and Co-ordinator of Care than did their supervisors, while the reverse occurred for the areas of Communicator and Member of the Profession.

An examination of the self ratings for specific items within each role area (See Appendix 7) shows no significant differences between the two groups. With the exception of the Communicator area, WAIT and hospital graduates perceived that they were performing at similar levels. There was a slight tendency for WAIT graduates to rate themselves more highly in the Communicator area.

Table 6.8 Self ratings for each role area

WAIT GRADUATES (n = 8)			HOSPITAL GRADUATES (n = 12)			COMBINED WAIT AND HOSPITAL GROUPS (n = 20)		
Out-standing/ above av.	Above av./ average	Below average	Out-standing/ above av.	Above av./ average	Below average	Out-standing/ above av.	Above av./ average	Below average

ROLE : HEALTH TEACHER

No.	3	5	0	5	7	0	8	12	0
%	38	63	0	42	58	0	40	60	0

ROLE : PROVIDER OF CARE

No.	5	3	0	7	5	0	12	8	0
%	63	38	0	58	42	0	60	40	0

ROLE : CO-ORDINATOR OF CARE

No.	2	6	0	3	9	0	5	15	0
%	25	75	0	25	75	0	25	75	0

ROLE : COMMUNICATOR

No.	3	5	0	4	8	0	7	13	0
%	38	63	0	33	67	0	35	65	0

ROLE : MEMBER OF THE PROFESSION.

No.	1	7	0	3	9	0	4	16	0
%	13	88	0	25	75	0	20	80	0

Table 6.9 Comparisons of self and supervisor ratings

Role Area	Supervisor ratings higher	Ratings similar	Self ratings higher
Health teacher			☆
Provider of care		☆	
Co-ordinating care			☆
Communicator	☆		
Member of the profession	☆		

Self ratings tended to be higher than supervisor ratings for specific items in the areas of Health Teacher, Co-ordinator of Care and Member of the Profession.

6.3 OVERALL RATINGS OF NURSING PERFORMANCE

Ratings of overall nursing performance obtained in the supervisor interviews are shown in Table 6.10.

Table 6.10 Mean supervisor ratings for overall performance

	WAIT GRADUATES (n = 8)*			Hospital GRADUATES (n = 13)*			Combined WAIT and Hospital Groups		
	Outstanding/ above average	Above average/ average	Below average	Outstanding/ above average	Above average/ average	Below average	Outstanding/ above average	Above average/ average	Below average
No.	4	3	0	4	8	0	8	11	0
%	51	43	0	33	67	0	42	58	0

*Rating from one supervisor not available.

Key: Outstanding/above average = mean for 2 supervisors between
4.0 - 5.0

Above average/average = mean for 2 supervisors between
3.0 - 3.9

Below average = mean for 2 supervisors between 1.0 - 2.9

While the proportion of WAIT graduates rated highly is greater than that for hospital graduates, in view of the small numbers and sampling procedures, the cautious conclusion is drawn that there is no demonstrable difference in performance between the two groups. The assessment of larger numbers of graduates would be necessary to draw any firm conclusions concerning the apparent trend in favour of the WAIT graduates.

CHAPTER 7

SUMMARY AND CONCLUSIONS

7.1 INTRODUCTION

This study aimed to develop and use procedures for the measurement of nursing performance in the working situation, and to apply these to the measurement of performance of graduates from college-based and hospital-based nursing courses in Western Australia.

Two quantitative procedures were used - the Nursing Performance Instrument (NPI) which had previously been developed by the nursing research group at Monash University, and the Nursing Performance Rating Form (NPRF) which was developed as part of this study. In addition, a variety of qualitative sources of information concerning both performance and the nursing context were utilized.

Three main conclusions have been drawn from this study :

- a) Within the substantial constraint of limited numbers of available graduates, and bearing in mind important methodological limitations which are further discussed in this chapter, this study has not demonstrated any significant differences in the nursing performance of graduates from a college-based course (WAIT) and hospital-based courses. This results from comparisons between the performance of WAIT graduates with an average of eight months working experience and hospital graduates with an average of nine months working experience; approximately fifty percent of the hospital graduates were working in the hospital in which they were trained. This is in general accord with the findings of the Victorian study (McArthur, Bruni and Brooke, 1981).
- b) The context in which nursing occurs is an important determinant of performance. The Victorian study demonstrated that the performance of hospital graduates tended to be higher if they were nursing in the teaching hospital in which they had been trained. Through an

examination of the relationships between the specific nursing context and performance, it is concluded from this study that the effect of context is to so mediate performance that observed actual performance may be significantly different from potential performance, that is, that which the nurse is capable of demonstrating. Put another way, in measuring the performance of a nurse, one is measuring both the context and the nurse.

- c) In addition to its mediating effect on performance, context - or rather, variations in context - also restricts evaluation of the nursing performance of groups, when performance is assessed in terms of criteria such as those contained in the Statement of Competencies of the Nurses Board of Western Australia. It is our view that the contextual factors may be so strong that it may not be possible to demonstrate significant differences in performance between different groups, regardless of the measurement procedure used.

A fourth conclusion emerges from the study, although this was not an original purpose. Graduates were observed in four different types of nursing situation, each within a different hospital. Between those situations there were differences in the manner in which nursing was practised, as is to be expected. In particular, there were substantial differences between actual practice and the practice - or nursing process - described in the Statement of Competencies of the Nurses Board of Western Australia.

The fact that no significant differences in performance were observed between the two groups could be accounted for in a number of ways. First, it may be that the measurement procedures and instruments were reliable and valid, and were able to measure nursing performance with precision and discrimination. If so, one may conclude that there were in fact no differences in performance between the two groups.

Secondly, it may be that differences in performance actually exist, but that the measuring procedures were not sufficiently precise to detect these; they were unable to measure with sufficient precision to enable discrimination between different levels of performance.

Thirdly, it may be that the two types of graduate are capable of different types and levels of performance (by virtue of their courses of training) but that these differences were obscured by other factors, with the result that differences in actual performance were not observed.

It is our view that a combination of the second and third explanations applies, and that the factors obscuring differences in performance arise from the context in which nursing occurs.

In the discussion which follows in which the above points are expanded, the focus is on the procedures specifically developed within this project, namely the NPRF.

7.2 CRITERIA, VALIDITY OF MEASUREMENT, AND CONTEXT: THE EFFECT OF CONTEXT ON MEASUREMENT

The Nurses Board Statement of Competencies is based on contemporary thinking and is intended to provide a description of the necessary competencies of the individual nurse. The effectiveness of the NPRF as an instrument based on the Nurses Board Statement for assessing and comparing performance depends on several factors.

Among these are the extent to which different supervisors, when using the rating form, ascribe the same meanings to items on the form, and the extent to which these meanings are consistent with the intent of the Nurses Board Statement. Evidence from the manner in which the NPRF was completed by supervisors, together with the supervisor interviews, indicated that such differences did exist - despite the conduct of training workshops.

By way of illustration, as described in Chapter 5, the health teaching role can be considered at three levels. The first involves the provision of information concerning, for example, what is or will be happening to the patient. The second level consists of non-intentional teaching which may often be patient initiated or facilitated whereby for example, the nurse, in response to questions from the patient, provides

information, explanations or teaching as is required. The Health Education scale of the NPI is predominately made up of activities at these two levels. The third level, which is the main focus of the Nurses Board Statement, involves nurse initiated teaching as a deliberate process involving an assessment of the patient's needs for teaching and existing level of knowledge, and the resulting planning and conduct of the teaching activity. Such components are reflected in the design of the NPRF. However, it was apparent that a number of the supervisors understood teaching at the first two levels and rated graduates accordingly.

A further requirement for the effectiveness of the NPRF was that supervisors had sufficient opportunities to observe performance in relation to each of the roles. The "insufficient observed" category indicated that in a number of areas supervisors often considered that they had not had sufficient opportunities to observe performance. In addition, supervisors (or any observer, for that matter) may simply be unaware - for good reasons - of what is actually occurring. For example, in the Provider of Care area a supervisor might judge that a nurse has frequent opportunities to formulate plans for total, individual patient care. However, there may not be a requirement in that ward situation that care plans be formally recorded. As a result a nurse may not appear to plan for total patient care (and be so rated by the supervisor), but may in fact implement total patient care at the bedside.

This leads to a further requirement for the effectiveness of procedures which involve the observation of actual performance (including both NPRF and NPI). This is that the graduates observed have sufficient opportunities to demonstrate competencies for each of the roles being studied. It is in this respect that the context becomes of particular importance. As described in Chapter 5, these opportunities varied considerably from one hospital situation to another. Depending on the nature of the hospital and the ward, on local policies and practices concerning the provision of care, and other contextual factors, each nursing role may manifest itself differently in different nursing contexts - and may be more-or-less consistent with the intent of the

Nurses Board Statement. Further, the organisation of patient care within a particular nursing situation may be such that there is a division of responsibility between nurses; through such a differentiation of roles any one individual may have only limited opportunities to develop and display particular competencies. At the same time, while the classification of functions into five role areas for the NPRF and fourteen role areas for NPI is conceptually useful, nursing occurs as an integrated activity in which many roles are inter-related, with the nature of the interrelationship also being dependent on context.

In summary, if nurses are performing different activities, in different situations, with different organizational expectations, then the level of performance of those activities cannot directly be compared unless the nature of the context is taken into account.

The intent of the matching procedures used in this study was to reduce the effects arising from context. If two nurses are properly matched - that is, they are working in the same ward, on the same shift, under the same supervisor and have similar duties, then comparisons between the two are, of course, valid. Comparing or combining results from different contexts is equivalent to combining different units of measurement, even though these may have the same name. The actual aspects of performance observed, and the interpretations or meanings of these, vary from one context to another. And each of these may in turn be different from the 'units' implicit in the Nurses Board criterion statement. In other words one may be combining and comparing measures of apples with measures of oranges, while assuming that in each case avocados are being measured - and not even know it.

Within a particular nursing situation, measurements and comparisons using external criteria such as the Nurses Board Statement can be achieved if the criteria are first adapted to, or explained in terms of, the context. Measurement of performance, within context, can then be used for such purposes as staff review, certification, assessment of the quality of care or the study of the nursing procedures in a hospital. The NPRF (appropriately adapted) would be useful for this purpose.

The making of comparisons across contexts would require an additional component not included in this study, which involves the making of a further level of subjective judgements. In addition to the actual measurement of nursing performance (using NPI or NPRF type procedures for example), this would involve a detailed understanding of the context in which a particular nurse was working, enabling a statement such as

"Taking into account the constraints and expectations inherent in the context, the level of performance of Nurse X in the area of Health Teaching is....."

Alternatively, if information were available concerning the underlying and essential components of the nursing process - the lowest common denominator which applied across all nursing situations - the measurement of performance could be made in these terms. Currently, the nursing process is insufficiently well understood to permit such an approach; even if it were, the result could be the reduction of a complex process to a set of behaviours which did not do justice to a process which is both an art and a science.

7.3 THE EFFECTS OF CONTEXT ON PERFORMANCE: SOCIALISATION

As discussed in Chapter 5 and in the preceding section, actual nursing performance is the resultant of many factors. In addition to the manner in which context interferes with the measurement and comparison of performance, this study has demonstrated, in qualitative terms, the manner in which a range of factors influence actual performance. These relationships are summarised in Figure 7.1, which constitutes an extension of Figure 3.1 in Chapter 3.

The relationships between factors are complex, interactive and dynamic. For the purpose of this discussion, they may be seen as consisting of two main types: input factors - those the nurse brings to the working situation - and organisational factors, which mediate the functioning of the nurse.

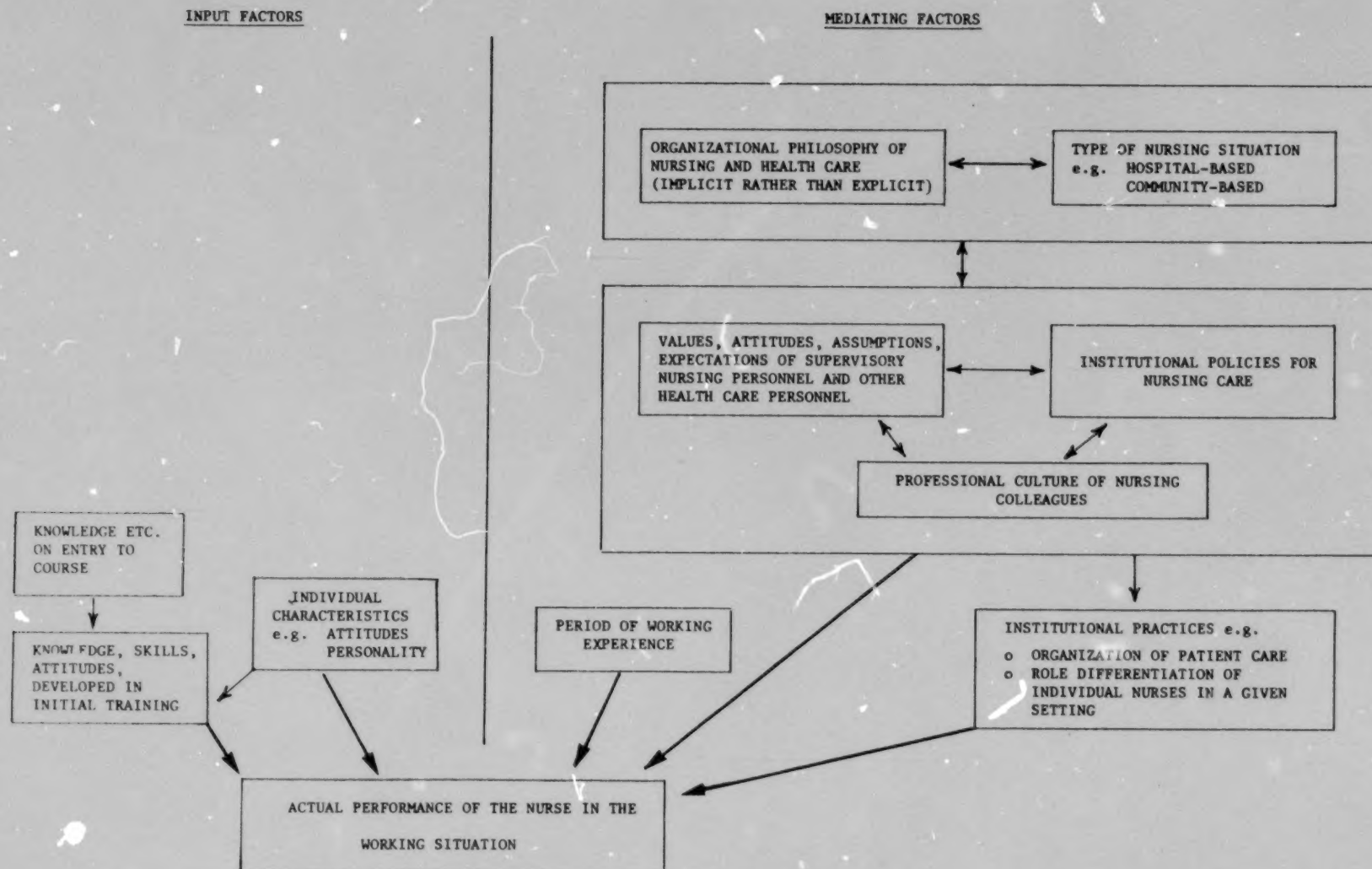


FIGURE 7.1 : FACTORS AFFECTING NURSING PERFORMANCE

The mediating factors arise either from the nature and philosophy of the organisation and the type of nursing situation (for example, whether hospital-based or community-based nursing) and from the values, attitudes, assumptions and expectations of individuals such as supervisors, nursing colleagues, other health care professionals or administrators. The nurse perceives a set of expectations, conveyed implicitly or explicitly, which serves to mediate the way in which she actually nurses. Even though the graduate may understand and be able to operate according to the nursing process as described in the Nurses Board Statement of Competencies, there is a strong tendency to conform to the procedures, practices and expectations perceived in the working situation. The evidence obtained in this study suggests that these mediating effects are powerful during the first year of nursing, and militate against the demonstration of differences in performance. In other words, even if performance could be measured with precision and the effects of context on its measurement taken into account, the effects of socialisation may result in differences not being observable.

The study also showed that a degree of incongruence existed between the opportunities provided by the actual working situation and that which graduates considered to be desirable. Graduates in both groups (WAIT group and hospital group) considered that they would obtain greater satisfaction in nursing situations which provided greater continuity of care, enabled the assumption of more personal responsibility and the opportunity to take initiatives, and which allowed them to get to know patients better. They perceived that their actual working situations did not adequately provide these opportunities.

7.4 DIRECTIONS FOR FUTURE RESEARCH

In addition to the conclusions discussed in preceding sections of this chapter, a number of recommendations and suggestions are made for activity which might follow this study.

a) The evaluation of nursing performance

It is recommended that further research which aims to compare the nursing performance of graduates from hospital- and college-based

courses be entered into cautiously. In addition to (or even in place of) the use of NPRF- and NPI- type quantitative measures, there should be extensive use of qualitative procedures which involve interviews with supervisors, graduates, nursing colleagues and others, and observation of the nursing context as well as the nurse at work, in order to elucidate the relationships between context and performance, thereby enabling the making of more insightful judgements about performance.

b) The further study of the nursing process

To enable a better understanding of how nursing is actually performed in Western Australian hospitals and other nursing situations, it is recommended that descriptive studies be made of nursing in a variety of contexts. Such information would be useful to institutions and to the Nurses Board of Western Australia in assessing the relationships between desirable practice (as contained in the Statement of Competencies) and actual practice. It would also be useful to Schools of Nursing for course planning purposes.

c) Follow-up studies of graduates

In view of the influence of context early in the career of a graduate, it may be that differences in courses are expressed through the career patterns, attitudes, satisfactions and aspirations of graduates some years after graduation. It is recommended that a series of relatively simple studies be implemented, which would involve interviews over the first several years after graduation to obtain information on the reasons for career patterns, and the attitudes, satisfactions and aspirations of graduates.

d) The further use of NPRF

At the level of individual hospitals or other nursing situations, or schools of nursing, it is suggested that this instrument be adapted to assist the development of institution-specific performance evaluation procedures, either to enable performance appraisal to be conducted in the working situation, or to evaluate clinical

performance during training, for purposes of teaching and/or certification.

e) Professional socialization

It is recommended that further studies of the socialization process be conducted, to seek answers to the following questions:

- i) What is the impact of the college programme on the one hand, and of the hospital and clinical settings on the other, on the professional socialization of nurses?
- ii) What is the impact of the hospital-based programme on the one hand, and of the hospital and clinical settings on the other, on the professional socialization of nurses?
- iii) While this study and others have demonstrated that the attitudes and competencies developed by nursing education programmes may not be fully realized in the working situation because of the influences of socialization, a detailed understanding of these influences is not available. Studies which elucidate these influences and relationships are recommended.
- iv) A socialization process also occurs in nursing education programmes whether based in colleges or hospitals. What is the nature of this process through for example, the effects of lectures, staff ideologies and attitudes or instructional approaches? In particular, the clinical experiences within courses warrant special attention, in order to examine the effects of these experiences in shaping professional expectations, perspectives and attitudes.

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Appendix 1

Statement of Competencies of the Registered
Nurses : Nurses' Board of Western Australia

NURSES BOARD OF WESTERN AUSTRALIA

COMPETENCIES OF THE REGISTERED NURSE

There are 5 inter-related roles -

1. Health Teacher
2. Provider of Care
3. Co-ordinator
4. Communicator
5. Member of the Nursing Profession

1. As a Health Teacher the nurse

- i. Assesses client/patient needs for information to support and maintain health.
- ii. Implements plans that are specific to the client/patient level of development and knowledge.
- iii. Supports and reinforces the teaching plans of other health professionals.
- iv. Evaluates the effectiveness of client/patient learning and modifies the plan as necessary.
- v. Assists other nursing personnel to develop skills in health teaching.

2. As a Provider of Care the nurse uses the problem solving nursing process to

- i. Assess: the collection of data from all available resources to formulate a nursing history as the basis for assessing needs and identifying problems - (a nursing diagnosis).
- ii. Plan: developing plans and establishing priorities of care, using the client/patient and family as resources; to establish expected outcomes.
- iii. Implement: carrying out planned nursing intervention according to established nursing principles. (examples of essential nursing intervention skills attached).
- iv. Evaluate: appraising the client/patient outcomes of the nursing intervention, modifying the care plan as necessary.

- v. Participate with client/patient, family and colleagues in evaluation of progress towards long and short term goals.

3. As a Co-ordinator of Care the nurse

- i. Assesses needs and sets nursing care priorities.
- ii. Provides client/patient care utilizing resources and assigns nursing personnel commensurate with their educational preparation and experience.
- iii. Revises the nursing plan and resets priorities in untoward or emergency situations.
- iv. Assures that care provided by all team members allows client/patient optimum rest.

4. As a Communicator the nurse

- i. Assesses and responds to verbal and non-verbal communications.
- ii. Considers individual differences in all communication.
- iii. Uses appropriate lines of authority and communication within the work setting.
- iv. Communicates and records assessments, nursing care plans, interventions and evaluations, accurately and promptly.
- v. Establishes and maintains effective communication with client/patient family and colleagues.
- iv. Considers legal responsibilities in all communication.
- vii. Communicates client/patient needs through the appropriate use of referrals.
- viii. Evaluates effectiveness of own communication.

5. As a member of the Profession the nurse

- i. Is accountable for her nursing practice.
- ii. Practises within the profession's ethical and legal framework.
- iii. Assumes responsibility for self-development and uses resources for continued learning.

- iv. Consults with a more experience registered nurse when client/patient problems are not within the scope of practice.
- v. Participates in nursing research.
- vi. Assits other nursing personnel to develop nursing ability.
- vii. Works within the policies of the employer.
- viii. Recognises policies and nursing practices that may impede client, patient care or contravene the law, and works within the organisational framework to initiate change.
- ix. Participates in the activities of professional organisations.

NURSES BOARD OF WESTERN AUSTRALIA

ESSENTIAL INTERVENTION SKILLS

1. Maintains and promotes respiratory function (eg oxygen therapy, etc., positioning etc).
2. Maintains and promotes nutritional status (eg dietary regimes, supplemental therapy, intravenous infusions, etc).
3. Maintains and promotes elimination (eg bowel and bladder regimes).
4. Maintains and promotes a balance of activity, rest, and sleep (eg planned activities of daily living, environmental adjustment, exercises, sensory stimuli, assistive devices etc).
5. Maintains an environment which supports physiological functioning, comfort, and relief of pain.
6. Maintains and promotes all aspects of hygiene.
7. Maintains and promotes physical safety, implementation of aseptic techniques, ambulations and transport; radiation safeguards.
8. Maintains and promotes independence.
9. Maintains and promotes physiological safety through consideration of each individual's worth and dignity and applies nursing measures which assist in reducing stress.
10. Measures basic physiological functioning and reports significant findings (eg vital signs, fluid intake and output).
11. Administers prescribed medications safely.
12. Intervenes in situations where:
 - basic life support systems are threatened (eg cardiopulmonary resuscitation; obstructive airway manoeuvre).
 - untoward physiological or physiological re-actions are probable.
 - changes in normal behaviour patterns have occurred.
13. Participates in established institutional emergency disaster plans.

Appendix 2

Nursing Performance Rating Form (NPRF)

- A. Supervisor Assessment
- B. Self-Assessment
- C. Explanatory Notes

WESTERN AUSTRALIAN INSTITUTE OF TECHNOLOGY

EDUCATIONAL DEVELOPMENT UNIT

NURSING EDUCATION EVALUATION PROJECT

NURSING PERFORMANCE RATING FORM : SUPERVISOR ASSESSMENT

Copyright © Alan Lonsdale
Sally Hooke
Christine Norvilas

Version 1, November, 1981.

NAME OF REGISTERED NURSE

DATE OF REGISTRATION

HOSPITAL

WARD NAME/NUMBER

WARD TYPE

RATER'S NAME

RATER'S POSITION

LENGTH OF TIME (IN WEEKS) THAT RATER HAS WORKED WITH THE ABOVE R.N.

DATE

INSTRUCTIONS:

This instrument has been devised in order to evaluate the performance of registered nurses. It focuses on five inter-related nursing roles:

- 1) Health Teacher
- 2) Provider of Care
- 3) Co-ordinator
- 4) Communicator
- 5) Member of the Profession

You are asked to make an assessment of the frequency with which the registered nurse performs in the manner specified on various dimensions of nursing competence. For example, in the area of Health Teacher:-

	Consistently	Frequently	Occasionally	Rarely	Insufficiently Observed
10. Assists other nursing personnel to develop their teaching ability		✓			

In this example, the person making the rating has specified that the nurse in question frequently takes the opportunity to assist other nursing personnel to develop their teaching ability.

You will notice a category on the scale labelled "Insufficiently Observed". This is to be used when the person making the judgement realizes that he/she has not been in a position to observe the R.N. sufficiently to be able to make an assessment on that item. For example, in the area of Member of the Profession:

17. Practices effectively whilst under pressure.

It may be that the person making the judgement has not been present when the R.N. has been under pressure. It would therefore be inappropriate to make any assessment and the 'Insufficiently Observed' category should be used.

It is realized, too, that in certain work situations, for various reasons, opportunities to demonstrate particular competencies may be limited. It is then desirable to obtain an indication of the opportunity the R.N. has had to demonstrate particular behaviours. For this reason, for certain items, a further scale has been included:

The R.N. has had the opportunity to demonstrate these behaviours

Frequently	Occasionally	Rarely	Never	
		✓		10. Assists other nursing personnel to develop their teaching ability.

In this example, the R.N. has rarely had the opportunity to assist other nursing personnel to develop their teaching ability but, as is seen in the initial example, she frequently takes advantage of any opportunities which do arise.

HEALTH TEACHER

A.(i) Health teaching is an important aspect of the role of a Registered Nurse (R.N.).

strongly agree agree disagree strongly disagree

(ii) Health teaching is an important aspect of R.N. _____'s work in this ward.

strongly agree agree disagree strongly disagree

B. I have observed him/her acting as a health teacher.

frequently occasionally rarely never

C. On the basis of my observations, I feel I can make informed judgements about this R.N.'s work as a health teacher.

with considerable confidence with some confidence with little confidence with no confidence

This R.N. has had the opportunity to demonstrate these behaviours:

Frequently Occasionally Rarely Never

1.a) _____

b) _____

c) _____

2.a) _____

b) _____

c) _____

3.a) _____

b) _____

c) _____

4.a) _____

b) _____

c) _____

As a health teacher, he/she Consistently Frequently Occasionally Rarely Insufficient Observed

1. Takes advantage of opportunities for teaching of

a) patients. _____ _____ _____ _____ _____
b) relatives. _____ _____ _____ _____ _____
c) colleagues. _____ _____ _____ _____ _____

2. Encourages questions from

a) patients. _____ _____ _____ _____ _____
b) relatives. _____ _____ _____ _____ _____
c) colleagues. _____ _____ _____ _____ _____

3. Is responsive to questions and/or "feelings" from

a) patients. _____ _____ _____ _____ _____
b) relatives. _____ _____ _____ _____ _____
c) colleagues. _____ _____ _____ _____ _____

4. Tailors explanations to suit the individual level of understanding of

a) patients. _____ _____ _____ _____ _____
b) relatives. _____ _____ _____ _____ _____
c) colleagues. _____ _____ _____ _____ _____

5. a) _____	_____	_____	_____	5. Explanations are appropriate to the needs and circumstances of				
b) _____	_____	_____	_____	a) patients.	_____	_____	_____	_____
c) _____	_____	_____	_____	b) relatives.	_____	_____	_____	_____
				c) colleagues.	_____	_____	_____	_____
				6. Bases teaching on factually correct information.	_____	_____	_____	_____
7. _____	_____	_____	_____	7. Refers patients/relatives/colleagues to appropriate sources of information when necessary. (e.g. written information, other health agencies)	_____	_____	_____	_____
				8. Gives appropriate advice prior to discharge to				
8a) _____	_____	_____	_____	a) patients.	_____	_____	_____	_____
b) _____	_____	_____	_____	b) relatives.	_____	_____	_____	_____
9. _____	_____	_____	_____	9. Modifies teaching plan, technique or approach when necessary.	_____	_____	_____	_____
				10. Assists other nursing personnel to develop their teaching ability.	_____	_____	_____	_____
10. _____	_____	_____	_____	11. Supports and reinforces the teaching activities of				
				a) nursing colleagues.	_____	_____	_____	_____
11a) _____	_____	_____	_____	b) other health professionals.	_____	_____	_____	_____
b) _____	_____	_____	_____					

For question 12, please indicate where you think this R.N.'s level of performance fits on this continuum according to the key given below.

5	4	3	2	1
Performance effects outstanding results.	Performance effects noticeably above average results.	Performance effects adequate/average results.	Performance effects noticeably below average results.	Performance effects totally inadequate results.

12. This R.N.'s overall performance as a health teacher.

5 4 3 2 1

PROVIDER OF CARE

A. What is the nature of the written and/or verbal plans for nursing care formulated on your ward?

This R.N. is involved in formulating plans for total individual patient care:

Frequently Occasionally Rarely Never

— 1 —

B. In what way is R.N. _____ involved in the formulation of these plans?

PLANNING OF CARE

The R.N. has had the opportunity to demonstrate these behaviours:

Frequently Occasionally Rarely Never

1. What sources of information does he/she usually use when formulating his/her plans for care?

Within the context of this nursing situation, when determining the care to be given:-

	Consistently	Frequently	Occasionally	Rarely	Insufficient Observed
2. Ensures that the care covers the full range of patient's needs.					

3. Systematically utilizes relevant information.

4. The expected patient outcomes embodied in her plans for care are realistic/achievable.

5. In determining care to be given, involves

a) the patient.

b) the relative(s).

6. When appropriate, plans for continuing care.

IMPLEMENTATION OF CARE

7. Ensures that plans for care are followed through.

8. a) Involves the patient, when appropriate, in nursing care procedures.

b) Involves the relatives, when appropriate, in nursing care procedures.

9. Is flexible in accommodating care procedures to patient's needs/wishes, when appropriate. _____
10. Practices in such a way as to ensure patient safety. _____
11. Is skillful in the performance of common procedures. _____
12. Is appropriately quick with procedures. _____
13. Provides for and maintains
- a) patient's physical comfort. _____
- b) patient's emotional well-being. _____

EVALUATION OF CARE

14. Regularly updates and, when necessary, modifies plans for care. _____
15. In evaluating care given, utilizes feedback from
- a) patients. _____
- b) relatives. _____
- c) colleagues. _____

On the basis of the above information, please give this R.N. an overall rating as a Provider of Care indicating his/her level of performance on the continuum below according to the following level:

- | | | | | |
|--|---|---|---|---|
| 5 | 4 | 3 | 2 | 1 |
| Performance effects outstanding results. | Performance effects noticeably above average results. | Performance effects adequate/average results. | Performance effects noticeably below average results. | Performance effects totally inadequate results. |
16. This R.N.'s overall performance as a Provider of Care. 5 4 3 2 1

CO-ORDINATOR OF CARE

1. On the basis of my observations, I feel that I can make informed judgements about R.N. _____'s effectiveness as a co-ordinator of

a) individual patient care

with considerable
confidence

with some
confidence

with little
confidence

with no
confidence

b) ward activities

with considerable
confidence

with some
confidence

with little
confidence

with no
confidence

This R.N. has had the opportunity to demonstrate these behaviours:-

Frequently Occasionally Rarely Never

Your observations of this R.N. have demonstrated that he/she

2. When nursing individual patients

Consistently

Frequently

Occasionally

Rarely

Insufficient
Observed

a) sets appropriate priorities for action.

b) acts effectively on those priorities.

3. When nursing groups of patients

a) sets appropriate priorities for action.

b) acts effectively on those priorities.

4. Ensures that all the necessary materials/resources are at hand before commencing procedures.

5. Carries out nursing care procedures concurrently when appropriate.

6. Arranges for continuing care of patients after discharge when appropriate.

6. _____

7. _____
8. _____
9. _____
10. _____
11. _____
7. Takes responsibility for co-ordinating all aspects of patient care (i.e. non-nursing as well as nursing care). _____
8. Co-ordinates nursing care with the activities of other staff so as to maximise patient well-being. _____
9. Willingly accepts responsibility for ward management. _____
10. Assigns tasks and responsibilities to others appropriately (e.g. expertise workload, competence). _____
11. Effectively resets priorities in order to cope with emergency or untoward situations. _____

For questions 14 and 15, please indicate where you think this R.N.'s level of performance fits on each continuum according to the key given below.

	5 Performance would effect outstanding results.	4 Performance would effect noticeably above average results	3 Performance would effect adequate/ average results.	2 Performance would effect noticeably below average results.	1 Performance would effect totally inadequate results.
12. This R.N.'s performance as a supervisor of other staff.	5	4	3	2	1
13. This R.N.'s performance if in charge of a ward.	5	4	3	2	1
14. This R.N.'s performance as a co-ordinator of <u>individual patient care</u> .	5	4	3	2	1
15. His/Her overall performance as a co-ordinator of care.	5	4	3	2	1

COMMUNICATOR

1. I feel confident, on the basis of my observations, that I am able to make informed judgements about the effectiveness and style of R.N. _____'s communications with

	Strongly agree	agree	disagree	Strongly disagree
(a) patients.	_____	_____	_____	_____
(b) relatives.	_____	_____	_____	_____
(c) colleagues.	_____	_____	_____	_____
(d) other staff.	_____	_____	_____	_____

This R.N. has had the opportunity to demonstrate these behaviours:-

Frequently Occasionally Rarely Never

6. _____
7. _____
8. _____
9. _____
10. _____
11. _____

A. COMMUNICATING TO COLLEAGUES AND OTHER HEALTH PROFESSIONALS

	VERBAL	Consistently	Frequently	Occasionally	Rarely	Ins. Obs.
2. Is comprehensive.	_____	_____	_____	_____	_____	_____
3. Information provided is relevant.	_____	_____	_____	_____	_____	_____
4. Is clear and understandable.	_____	_____	_____	_____	_____	_____
5. Reports information accurately.	_____	_____	_____	_____	_____	_____
6. <u>WRITTEN</u> Is comprehensive.	_____	_____	_____	_____	_____	_____
7. The information provided is relevant.	_____	_____	_____	_____	_____	_____
8. Records information accurately.	_____	_____	_____	_____	_____	_____
9. The information provided is systematically recorded.	_____	_____	_____	_____	_____	_____
10. Is clear and understandable.	_____	_____	_____	_____	_____	_____
11. Is attentive to legal responsibilities.	_____	_____	_____	_____	_____	_____

12. a) _____

b) _____

15. a) _____

b) _____

c) _____

17. a) _____

b) _____

B. COMMUNICATING TO OTHERS (E.G. PATIENTS, RELATIVES, COLLEAGUES AND OTHER HEALTH PROFESSIONALS)

12. Effectively communicates information regarding patient progress _____

(a) to the patient concerned. _____

(b) to relative(s). _____

13. Treats patients as individuals. _____

14. Encourages the expression of thoughts and feelings of patients. _____

15. Makes sure that his/her communications are understood by _____

(a) patients. _____

(b) relatives. _____

(c) colleagues. _____

C. RECEIVING COMMUNICATIONS FROM OTHERS (E.G. PATIENTS, RELATIVES, COLLEAGUES, AND OTHER HEALTH PROFESSIONALS)

16. Is sensitive to non-verbal communications _____

17. Is an attentive listener _____

(a) to patients _____

(b) to relatives _____

For question 18 please indicate where you think this R.N.'s level of performance fits on the continuum according to the key given below.

5
Performance
effects
outstanding
results.

4
Performance
effects noticeably
above average
results.

3
Performance
effects
adequate/average
results.

2
Performance
effects noticeably
below average
results.

1
Performance
effects
totally in-
adequate
results.

18. As a communicator this R.N.'s performance fits at level _____

5 4 3 2 1

MEMBER OF THE PROFESSION

RELATIONSHIPS WITH NURSING COLLEAGUES

In his/her relationships with nursing colleagues, this R.N.:-

This R.N. has had the opportunity to demonstrate these behaviours:

Frequently Occasionally Rarely Never

3. _____

1. Practises in such a way as to promote the confidence and self-esteem of other nurses.

Consistently Frequently Occasionally Rarely Ins.Obs.

2. Treats nursing staff fairly.

3. Guides or assists other nurses appropriately.

4. Show a preparedness to consult more experienced nurses when problems are beyond her expertise.

5. Accepts feedback regarding her performance, modifying her behaviour accordingly.

RELATIONSHIPS WITH HEALTH CARE PROFESSIONALS/OTHER STAFF

In his/her work with Health Care Professionals/other Staff he/she:-

6. _____

6. Facilitates effective working relationships with health care professionals.

7. _____

7. Facilitates effective working relationships with other staff.

8. _____

8. Works effectively within the policies of her employer.

9. _____

9. Demonstrates preparedness to initiate changes when the organizational framework impedes patient care.

PROFESSIONAL ATTRIBUTES

As a professional, this R.N.:-

10. _____

10. Accepts responsibility for her nursing actions and omissions.

	11. Readily accepts the responsibilities assigned to him/her.					
12.	12. Does not allow personal feelings/beliefs to interfere with the quality of care given.					
	13. Maintains confidentiality of patients communications and information.					
14.	14. Respects the rights of patients.					
	15. Is reliable.					
	16. Demonstrates confidence in her nursing ability.					
17.	17. Practises effectively whilst under pressure.					
18. a)	18. Demonstrates an interest in her professional development by	Yes	No	Don't know	If 'yes' please specify	
b)	(a) furthering her education.					
c)	(b) participation in professional activities.					
19.	(c) self evaluation of her practice.					
	19. Acts effectively within the framework of his/her legal responsibilities.					

On the basis of the above information, please give this R.N. an overall rating as a Member of the Profession indicating her level of performance on the continuum below, according to the following key.

5	4	3	2	1
Performance outstanding.	Performance noticeably above average.	Performance adequate/average.	Performance noticeably below average.	Performance totally inadequate.

20. This R.N.'s performance as a Member of the Profession

5 4 3 2 1

WESTERN AUSTRALIAN INSTITUTE OF TECHNOLOGY

EDUCATIONAL DEVELOPMENT UNIT

NURSING EDUCATION EVALUATION PROJECT

NURSING PERFORMANCE RATING FORM: SELF ASSESSMENT

Copyright © Alan Lonsdale
Sally Hooke
Christine Norvilas

Version 1, November, 1981

NAME _____
DATE OF REGISTRATION _____
HOSPITAL _____
WARD NAME/NUMBER _____
WARD TYPE _____
CHARGE SISTER _____
SECOND-IN-CHARGE SISTER _____
LENGTH OF TIME (IN WEEKS) THAT YOU HAVE WORKED IN THE ABOVE WARD _____

DATE: _____

INSTRUCTIONS

This instrument has been devised in order to obtain self evaluation of registered nurses regarding their nursing performance. It focuses on five inter-related nursing roles:

- 1) Health Teacher
- 2) Provider of Care
- 3) Co-ordinator
- 4) Communicator
- 5) Member of the Profession

You will notice that the format of the schedule consists of three main areas, namely, My Opinion, My Work Situation and My Performance.

The "My Opinion" Section seeks to obtain your opinion on some broad questions. For example, in the area of Health Teacher:-

A.(i) Health teaching is an important aspect of the role of the Registered Nurse (R.N.)

_____ ☒ _____
strongly agree agree disagree strongly disagree

In this example, the respondent has indicated that she thinks Health Teaching is important to the role of the R.N., but not very important.

In the "My Performance" section you are asked to make an assessment of the frequency with which you perform in the manner specified on various dimensions of nursing competence. For example, in the area of Health Teacher:-

Consistently Frequently Occasionally Rarely

10. I assist other nursing personnel to develop their teaching ability

_____ ☒ _____

In this example, the nurse making the rating has specified that she frequently takes the opportunity to assist other nursing personnel to develop their teaching ability.

"My Work Situation": It is realized that in certain work situations, for various reasons, opportunities to demonstrate particular competencies may be limited. It is then desirable to obtain an indication of the opportunity you (or any nurse in your position) have had to demonstrate particular behaviours. For this reason, for certain items, a further scale has been included:

I have had the opportunity to demonstrate these behaviours

Frequently Occasionally Rarely Never

_____ ☒ _____

10. Assists other nursing personnel to develop their teaching ability.

In this example, the R.N. has rarely had the opportunity to assist other nursing personnel to develop their teaching ability but, as is seen in the initial example, she frequently takes advantage of any opportunities which do arise.

When you have completed the form, please re-check that you have answered every question, both the "opportunity to perform" part and the "actual performance" part i.e. to the left and the right of every item.

HEALTH TEACHER

MY OPINION:

A. (i) Health teaching is an important aspect of the role of a Registered Nurse (R.N.)

strongly agree agree disagree strongly disagree

(ii) Health teaching is an important aspect of my work in this ward.

strongly agree agree disagree strongly disagree

B. I have acted as a health teacher.

frequently occasionally rarely never

C. On the basis of my observations, I feel that my Charge Sister and 2IC can make informed judgements about my work as a health teacher.

Charge strongly agree agree disagree strongly disagree

2IC strongly agree agree disagree strongly disagree

WORK SITUATION

Frequently Occasionally Rarely Never

1. a) _____

b) _____

c) _____

2. a) _____

b) _____

c) _____

3. a) _____

b) _____

c) _____

MY PERFORMANCE

Consistently Frequently Occasionally Rarely

1. I take advantage of opportunities for teaching of

a) patients

b) relatives

c) colleagues

2. I encourage questions from

a) patients

b) relatives

c) colleagues

3. I am responsive to questions and/or "feelers" from

a) patients

b) relatives

c) colleagues

8-

4 a) _____	_____	_____	_____	4. I tailor explanations to suit the level of understanding of	_____	_____	_____	_____
b) _____	_____	_____	_____	a) patients	_____	_____	_____	_____
c) _____	_____	_____	_____	b) relatives	_____	_____	_____	_____
				c) colleagues	_____	_____	_____	_____
5 a) _____	_____	_____	_____	5. My explanations are appropriate to the needs and circumstances of	_____	_____	_____	_____
b) _____	_____	_____	_____	a) patients	_____	_____	_____	_____
c) _____	_____	_____	_____	b) relatives	_____	_____	_____	_____
				c) colleagues	_____	_____	_____	_____
6. I base teaching on factually correct information.	_____	_____	_____	_____	_____	_____	_____	_____
7. I refer patients/relatives/colleagues to appropriate sources of information when necessary.	_____	_____	_____	_____	_____	_____	_____	_____
8. I give appropriate advice prior to discharge to	_____	_____	_____	_____	_____	_____	_____	_____
a) _____	_____	_____	_____	a) patients	_____	_____	_____	_____
b) _____	_____	_____	_____	b) relatives	_____	_____	_____	_____
9. I modify teaching plan, technique or approach when necessary.	_____	_____	_____	_____	_____	_____	_____	_____
10. I assist other nursing personnel to develop their teaching ability.	_____	_____	_____	_____	_____	_____	_____	_____
11. I support and reinforce the teaching activities of	_____	_____	_____	_____	_____	_____	_____	_____
a) _____	_____	_____	_____	a) nursing colleagues	_____	_____	_____	_____
b) _____	_____	_____	_____	b) other health professionals	_____	_____	_____	_____

For question 12, please indicate where you think your level of performance fits on this continuum according to the key given below.

5	4	3	2	1
Performance effects outstanding results	Performance effects noticeably above average results	Performance effects adequate/average results	Performance effects noticeably below average results	Performance effects totally inadequate results
12. My overall performance as a health teacher				

PROVIDER OF CARE

- A. What is the nature of the written and/or verbal plans for nursing care formulated on your ward?

- B. In what way are you involved in the formulation of the plans?

MY WORK SITUATION

I am involved in formulating plans for total individual patient care:

Frequently Occasionally Rarely Never

I have had the opportunity to demonstrate these behaviours:

Frequently Occasionally Rarely Never

2. _____

3. _____

4. _____

5. a. _____

b. _____

6. _____

MY PERFORMANCE

PLANNING OF CARE

1. What sources of information do you usually use when formulating your plans for care?

Within the context of this nursing situation, when determining the care to be given:

2. I ensure that the care covers the full range of patient's needs.

Consistently Frequently Occasionally Rarely

3. I systematically utilize relevant information.

4. The expected patient outcomes embodied in my plans for care are realistic/achievable.

5. In determining care to be given I involve

a) the patient.

b) the relative(s).

6. When appropriate, I plan for continuing care.

7. _____

8. a) _____

b) _____

9. _____

10. _____

11. _____

12. _____

13a) _____

b) _____

14. _____

15a) _____

IMPLEMENTATION OF CARE

7. I ensure that plans for care are followed through.

8. a) I involve the patient, when appropriate, in nursing care procedures.

b) I involve the relatives, when appropriate, in nursing care procedures.

9. I am flexible in accomodating care procedures to patient's needs/wishes.

10. I practise in such a way as to ensure patient safety.

11. I am skilfull in my performance of common procedures.

12. I am appropriately quick with procedures.

13. I provide for and maintain

a) patient's physical comfort.

b) patient's emotional well-being.

EVALUATION OF CARE

14. I regularly update and, when necessary, modify plans for care.

15. In evaluating care given, I utilize feedback from

a) patients.

b) relatives.

c) colleagues.

On the basis of the above information, please give yourself an overall rating as a Provider of Care indicating your level of performance on the continuum below according to the following key.

5	4	3	2	1
Performance effects outstanding results.	Performance effects noticeably above average results.	Performance effects adequate/average results.	Performance effects noticeably below average results.	Performance effects totally inadequate results.

16. My overall performance as a Provider of Care

5

4

3

2

1

CO-ORDINATOR OF CARE

MY OPINION

1. I feel confident that my charge sister and 2IC have observed me sufficiently to make informed judgments about my effectiveness as a co-ordinator of

(a) individual patient care

charge	☐ strongly agree	☐ agree	☐ disagree	☐ strongly disagree
2IC	☐ strongly agree	☐ agree	☐ disagree	☐ strongly disagree

(b) ward activities

charge	☐ strongly agree	☐ agree	☐ disagree	☐ strongly disagree
2IC	☐ strongly agree	☐ agree	☐ disagree	☐ strongly disagree

MY PERFORMANCE

2. When nursing individual patients

Consistently Frequently Occasionally Rarely

(a) I set appropriate priorities for action.

☐ ☐ ☐ ☐

(b) I act effectively on these priorities.

☐ ☐ ☐ ☐

3. When nursing groups of patients

(a) I set appropriate priorities for action.

☐ ☐ ☐ ☐

(b) I act effectively on those priorities.

☐ ☐ ☐ ☐

4. I ensure that all the necessary materials/resources are at hand before commencing procedures.

☐ ☐ ☐ ☐

5. I carry out nursing care procedures concurrently when appropriate.

☐ ☐ ☐ ☐

MY WORK SITUATION

I have had the opportunity to demonstrate these behaviours:

Frequently Occasionally Rarely Never

2.a) ☐ ☐ ☐ ☐

b) ☐ ☐ ☐ ☐

3.a) ☐ ☐ ☐ ☐

b) ☐ ☐ ☐ ☐

6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
6. I arrange for continuing care of patients after discharge when appropriate. _____
7. I take responsibility for co-ordinating all aspects of patient care (i.e. non-nursing as well as nursing care.) _____
8. I co-ordinate nursing care with the activities of other staff so as to maximise patient well-being. _____
9. I willingly accept responsibility for ward management. _____
10. I assign tasks and responsibilities to others appropriately (e.g. expertise, workload, competence.). _____
11. I effectively reset priorities in order to cope with emergency or untoward situations. _____

For questions 12 and 15, please indicate where you think your level of performance fits on each continuum according to the key given below.

	5	4	3	2	1		
Performance would effect outstanding results.	Performance would effect noticeably above average results.	Performance would effect adequate/average results.	Performance would effect noticeably below average results.	Performance would effect totally inadequate results.			
12. My performance as a supervisor of other staff.			5	4	3	2	1
13. My performance if in charge of a ward.			5	4	3	2	1
14. My performance as a co-ordinator of <u>individual</u> patient care.			5	4	3	2	1
15. My overall performance as a co-ordinator of care.			5	4	3	2	1

MY WORK SITUATION

I have had the opportunity to demonstrate these behaviours:

Frequently Occasionally Rarely Never

6. ☐ ☐ ☐ ☐
7. ☐ ☐ ☐ ☐
8. ☐ ☐ ☐ ☐
9. ☐ ☐ ☐ ☐
10. ☐ ☐ ☐ ☐
11. ☐ ☐ ☐ ☐

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MY OPINION

COMMUNICATOR

1. I feel confident, on the basis of their observations of me, that my Charge Sister and 2IC are able to make informed judgements about the effectiveness and style of my communications with

		Strongly agree	agree	disagree	Strongly disagree
(a) patients.	Charge	☐	☐	☐	☐
	2IC	☐	☐	☐	☐
(b) relatives.	Charge	☐	☐	☐	☐
	2IC	☐	☐	☐	☐
(c) colleagues.	Charge	☐	☐	☐	☐
	2IC	☐	☐	☐	☐
(d) other staff.	Charge	☐	☐	☐	☐
	2IC	☐	☐	☐	☐

MY PERFORMANCE

A. COMMUNICATING TO COLLEAGUES AND OTHER HEALTH PROFESSIONALS

VERBAL

- | | Consistently | Frequently | Occasionally | Rarely |
|---|--------------------------|--------------------------|--------------------------|--------------------------|
| 2. I am comprehensive. | ☐ | ☐ | ☐ | ☐ |
| 3. The information I provide is relevant. | ☐ | ☐ | ☐ | ☐ |
| 4. I am clear and understandable. | ☐ | ☐ | ☐ | ☐ |
| 5. I report information accurately. | ☐ | ☐ | ☐ | ☐ |

WRITTEN

- | | | | | |
|--|--------------------------|--------------------------|--------------------------|--------------------------|
| 6. I am comprehensive. | ☐ | ☐ | ☐ | ☐ |
| 7. The information I provide is relevant. | ☐ | ☐ | ☐ | ☐ |
| 8. I record information accurately. | ☐ | ☐ | ☐ | ☐ |
| 9. The information I provide is systematically recorded. | ☐ | ☐ | ☐ | ☐ |
| 10. I am clear and understandable. | ☐ | ☐ | ☐ | ☐ |
| 11. I am attentive to legal responsibilities. | ☐ | ☐ | ☐ | ☐ |

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B. COMMUNICATING TO OTHERS (E.G. PATIENTS, RELATIVES, COLLEAGUES AND OTHER HEALTH PROFESSIONALS)

12. I effectively communicate information regarding patient progress

12.a) _____
b) _____

(a) to the patient concerned. _____
(b) to relative(s). _____

13. I treat patients as individuals. _____

14. I encourage the expression of thoughts and feelings of patients. _____

15. I make sure that my communications are understood by

15.a) _____
b) _____
c) _____

(a) patients. _____
(b) relatives. _____
(c) colleagues. _____

C. RECEIVING COMMUNICATIONS FROM OTHERS (E.G. PATIENTS, RELATIVES, COLLEAGUES, AND OTHER HEALTH PROFESSIONALS)

16. I am sensitive to non-verbal communications. _____

17. I am an attentive listener
(a) to patients. _____

17.a) _____
b) _____

(b) to relatives. _____

For question 18, please indicate where you think your level of performance fits on the continuum according to the key given below.

5	4	3	2	1
Performance effects outstanding results.	Performance effects noticeably above average results.	Performance effects adequate/average results.	Performance effects noticeably below average results.	Performance effects totally inadequate results.

18. As a communicator, my performance fits at level

5 4 3 2 1

MY WORK SITUATION

I have had the opportunity to demonstrate these behaviours:

Frequently Occasionally Rarely Never

3. _____

6. _____

7. _____

8. _____

9. _____

10. _____

11. _____

12. _____

MY PERFORMANCE

RELATIONSHIPS WITH NURSING COLLEAGUES

1. I practise in such a way as to promote the confidence and self-esteem of other nurses.

2. I treat nursing staff fairly.

3. I guide or assist other nurses appropriately.

4. I show a preparedness to consult more experienced nurses when problems are beyond my expertise.

5. I accept feedback regarding my performance, modifying my behaviour accordingly.

RELATIONSHIPS WITH HEALTH CARE PROFESSIONALS/OTHER STAFF

6. I facilitate effective working relationships with health care professionals.

7. I facilitate effective working relationships with other staff.

8. I work effectively within the policies of my employer.

9. I demonstrate a preparedness to initiate changes when the organizational framework impedes patient care.

PROFESSIONAL ATTRIBUTES

10. I accept responsibility for my nursing actions and omissions.

11. I readily accept the responsibilities assigned to me.

12. I do not allow personal feelings/beliefs to interfere with the quality of care given.

MEMBER OF THE PROFESSION

Consistently Frequently Occasionally Rarely

- | | | | | | |
|--------|--|-------|-------|-------|-------|
| 13. | I maintain confidentiality of patients communications and information. | _____ | _____ | _____ | _____ |
| 14. | I respect the rights of patients. | _____ | _____ | _____ | _____ |
| 15. | I am reliable. | _____ | _____ | _____ | _____ |
| 16. | I demonstrate confidence in my nursing ability. | _____ | _____ | _____ | _____ |
| 17. | I practise effectively whilst under pressure. | _____ | _____ | _____ | _____ |
| 18. | I demonstrate an interest in my professional development by | | | | |
| 18. a) | (a) furthering my education. | _____ | _____ | _____ | _____ |
| 18. b) | (b) participation in professional activities. | _____ | _____ | _____ | _____ |
| 18. c) | (c) self evaluation of my practice. | _____ | _____ | _____ | _____ |
| 19. | I act effectively within the framework of my legal responsibilities. | _____ | _____ | _____ | _____ |

On the basis of the above information, please give yourself an overall rating as a Member of the Profession indicating your level of performance on the continuum below, according to the following key.

5	4	3	2	1
Performance outstanding.	Performance noticeably above average.	Performance adequate/average.	Performance noticeably below average.	Performance totally inadequate.

- | | | | | | | |
|-----|--|---|---|---|---|---|
| 20. | My performance as a Member of the Profession | 5 | 4 | 3 | 2 | 1 |
|-----|--|---|---|---|---|---|

HEALTH TEACHER

EXPLANATORY NOTES:

A(i) Health teaching examples

Explanations

- purpose of a procedure or a treatment.
 - the expected outcomes of procedures/treatments.
- e.g. 1) the reason for fasting pre-operatively
- e.g. 2) the reason for introducing food and fluids slowly post-operatively
- e.g. 3) why patient is on certain medications.
how the medications work.
side effects of medications.
- e.g. 4) why it is necessary to monitor B.P. every 4 hours or to have
certain tests, examinations done.
- e.g. 5) teaching patient how to manage certain things for him or herself
such as test urine, colostomy care, diabetic diet, care of
umbilicus of newborn.

EXPLANATORY NOTES

A. May include:

- e.g. written nursing care plans
- verbal handovers
- treatment book notes
- cardex systems etc.

B. Please state the nature of any direct involvement he/she has in planning patient care.
R.N. in question takes the initiative in deciding what care is to be given.

1. Sources of information include e.g.

- Patient history/records
- Doctors orders/orders from other Health Care Professionals
- Her own assessments - interviews with patients, relatives/others
- observations etc.

2. The plans are completely comprehensive - no aspect of patient care is neglected or overlooked. e.g.

- R.N. is giving out meals and realizes that he/she is unaware of the type of diet suited to the patient, or person to whom responsibility has been delegated.

3. That in formulating plans for care, the various pieces of information are organized into a coherent, logical form which can easily be followed by others.

4. That the objectives for patient care are realistic

- e.g. in terms of the response expected from the patient
- e.g. patient capabilities, i.e. physical and psychological commensurate with prognosis.
- e.g. in terms of logistics (availability of staff, and resources).

5. Involves patients and/or relatives in the planning stage of patient care by interviewing them/asking their opinions.

6. Planning for long-term care e.g., beyond discharge from hospital.

8. Elicits the patient's assistance when he/she is -

- (a) carrying out procedures, e.g., gets the patient to wash his/her face; allows the patient within his/her capabilities to participate actively in his/her own care (promotion of independence).
- (b) if relatives are willing and capable, involves them when appropriate in actively caring for the patient e.g. feeding patient.

9. For example, allows patient to sleep late into the morning rather than getting him/her up to have a shower; waits until patient's visitors have gone before commencing sponging; patient suggests that he/she does not want pre-operative sleeping tablets (i.e. night before operation).

10. Safety, e.g. supervising unsteady patient in bath or on a walk;

- e.g. testing temperature of bathwater, food,
- e.g. maintaining asepsis,
- e.g. washing hands between patients;
- e.g. proper observation of barrier nursing procedures;
- e.g. observation of patient so that potentially dangerous changes in condition are recognized early and acted upon;

11. Skillful performance is thoroughness, appropriate speed, dexterity, the following of principles such as asepsis, patient comfort and safety.

12. Not always desirable to be quick - speed should be appropriate to the situation.

13. For example, plan for care stipulates that patient is to be sponged in bed. Finds that patient is feeling considerably better and would love a bath. Patient having wound dressed four hourly judged to only require it twice a day.

PROVIDER OF CARE (cont'd)

14. a) For example, asks patient about his/her comfort with regard to positioning, bandaging, posturing for physiotherapy, especially with long term or chronically ill patients.
- b) R.N. asks relative if she has noticed that her mother appears to become distressed in the afternoons.
Relative reports that Mother gets distressed if she has to sit out of bed too long.
- c) R.H. asks nursing colleague if she knows why patient X is not eating.
Nursing colleague replies that she has noticed that patient X enjoys her meal and eats much better if she is allowed to eat at the table instead of in bed.

CO-ORDINATOR OF CARE

EXPLANATORY NOTES:

- 2.a) A 6-year old child has just been admitted to the ward. She is visibly distressed by the strangeness of her surroundings. The R.N. decides that it is more important to spend some time trying to put this child at ease rather than immediately follow routine admission procedures such as weighing, urine testing, etc.
- b) Obviously, to assess this, you must have seen or heard what these priorities are (e.g. in nursing care plans or verbal handover) before you can judge whether the R.N. has acted effectively. In answering the question, you should ask yourself "What were the outcomes (of her actions) for the patient?" Did she make efficient use of her time and resources?"
3. This question concerns the effectiveness of the nurse in co-ordinating care for several patients for whom she is responsible e.g. when she is in charge of a ward. She looks at what has to be done, what the needs of the patients are and decides on a course of action. Does she tackle the work in an appropriate order, or does she approach it in a haphazard way?
4. R.N. is inclined to forget the patient's toothbrush and toothpaste when she takes him or her for a bath.
5. Takes opportunity to reinforce and supervise physio exercises when sponging a patient in bed.
6. Consults with family of stroke patient re new fixtures in the home. Arranges for district nurse to call.
7. Does the R.N. have the opportunity to take this responsibility and, if so, does she take it? For example, if several people such as doctor, physio, social worker, dietitian and priest (as well as nurses) are contributing to the patient's care, does the R.N. attempt to co-ordinate their visits and their care?
8. Furthermore, does she attempt to co-ordinate the contributions of all these care-givers in such a way as to maximize the well-being of the patient - as distinct from the well-being of the nurse, or of the doctor?
9. How confidently does she accept the responsibility of being in charge of the ward?
11. Does she "go to pieces" (become disorganized and ineffective) when her routine is interrupted? Or is she flexible; can she think of alternative plans of action quickly; can she make decisions quickly which will effectively cater to changed circumstances.

MEMBER OF THE PROFESSION

1. Giving credit where credit due;
Praising others where appropriate;
Fostering independence and development.
5. Accepting feedback implies modification of behaviour.
e.g. it is brought to the attention of the charge sister that R.N. "X" assigns work to junior nurses which is beyond their level of competence. This is explained to the R.N. in question and it is apparent that her subsequent assignments are appropriate.
6. For example very junior nurse was upset because she had been asked by Dr to do something beyond her scope. R.N. intervenes to explain situation to Dr. and suggests alternative avenues for enlisting nursing staff assistance.
7. For example a ward clerk complains that her work is being hampered by nursing staff who fail to present certain paperwork for processing. The R.N. discusses the matter with her nursing colleagues who then comply with the ward clerk's request.
8. An untoward incident occurs involving Patient. According to hospital policy, this incident should be reported to nursing administration; however, the patient wishes the information to remain undisclosed. The R.N. would have to find a way to placate the patient on the one hand and to abide by hospital policy on the other.
9. For example, a staff shortage. An R.N. recognizes the implications of staff shortages for patient care and registers her concern to the appropriate authority.
10. For example, an R.N. has assigned a task to an inexperienced junior nurse. The task is performed inadequately. The R.N. admits that the fault lies with her for inappropriately designating the task.
11. For example, a charge sister asks the R.N. to conduct an informal tutorial on the ward regarding care of certain types of patients. The R.N. may readily accept the responsibility or may plead various excuses such as lack of time or lack of knowledge.
12. A negative example: A young mother still semiconscious as a result of an overdose, is sobbing uncontrollably. The R.N., in front of a junior nurse says exasperatedly, "I have no patience with these women, they don't care about anybody else but themselves". Her statement could prejudice the junior nurse.
13. A negative example: Two R.N.'s in a crowded lift are discussing the condition of a particular patient on their ward.
14. The patient, distressed by visits from medical students, asks the R.N. if she has to see them. The R.N. explains that she is within her rights to refuse to see them, and conveys the patient's request to the medical students.
19. Promptly filling out an incident form when patient falls out of bed.

Appendix 3

Supervisor Interview Questions

SUPERVISOR INTERVIEW QUESTIONS

1. Would you be happy to keep R.N. _____ on your ward, given that opportunity?

If yes, why?

If no, why not?

2. What are R.N. _____'s particular strengths in her nursing performance?

3. In what areas, if any, does R.N. _____ need to improve her nursing performance?

4. Do you feel that R.N. _____ came to your ward fully equipped to handle nursing on your ward?

If no, in which areas was her performance lacking.

5. Has she now demonstrated full functioning in these areas?

If no, in which is she still lacking?

6. How long did it take R.N. _____ to adapt to working on your ward?

7. Do you feel that this nursing environment in any way inhibits R.N. _____'s potential performance?

8. What nursing situation do you think is best suited to R.N. _____'s talents?

9. What is the nature of the nursing care plans used on your ward? A sample, please.

10. We have asked you to give R.N. _____ an overall rating of her performance in each of the 5 areas of nursing competence. Would you now like to suggest a global rating of R.N. _____'s performance as an R.N?

R.N. _____'s	5	4	3	2
overall per-	Performance	Performance	Performance	Performance
formance as	outstanding	noticeably	adequate/	noticeably
an R.N.		above average	average	below average.
		1		
		Performance		
		totally		
		inadequate		

Appendix 4

Supervisor Questionnaire:

Organisation of Patient Care

SUPERVISOR QUESTIONNAIRE

ORGANISATION OF PATIENT CARE

Name: _____

Hospital: _____

Ward No: _____

Ward Type: _____

Which of the following, given the definitions below, best describes how the care of patients is organised on your ward?

Tick the appropriate
box

- | | |
|--|--------------------------|
| 1. Task Oriented | ☐ |
| 2. Patient Allocation | ☐ |
| 3. Team Nursing: (a) Where care giving is predominantly task oriented. | ☐ |
| (b) Where care giving is predominantly by way of patient allocation | ☐ |
| (c) Where there is an equal mixture of task and patient allocation. | ☐ |
| 4. Other, please describe. _____ | ☐ |
| _____ | |
| _____ | |
| _____ | |
| _____ | |

Definitions:

Task Oriented: Where care giving is organized such that nursing staff are allocated to the performance of certain nursing tasks e.g. treatments, sponging, ward tidying etc.

Patient Allocation: Where individual nurses are responsible for the total care of one or more individual patients.

Team Nursing: Where a team of nurses, e.g. an R.N., student nurses and nursing aides are assigned a number of patients on a ward for whom they are to care. Care giving, within this framework may be:-

- a) predominantly task oriented
- b) predominantly patient allocation
- c) a more or less equal mixture of (a) and (b).

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Appendix 5

Self-Assessment Interview Questions

SELF ASSESSMENT INTERVIEW QUESTIONS

1. Would you be happy to continue working on this ward, given the opportunity?
If yes, why?
If no, why not?

2. What are your particular strengths in your nursing performance?

3. In what areas, if any, do you need to improve your nursing performance?

4. Do you feel that you came to this ward fully equipped to handle nursing here?
If no, in which areas was your performance lacking?

5. Do you feel that you now function to your full capability in these areas?
If no, ⁱⁿ which are you still lacking?

6. How long did it take you to adapt to working on this ward?

2.

7. Do you feel that this nursing environment in any way inhibits your potential performance?

8. What nursing situation do you think is best suited to your talents?

9. What is the nature of the nursing care plans used on this ward? A sample, please.

10. We have asked you to give yourself an overall rating of your performance in each of the 5 areas of nursing competence. Would you now like to suggest a global rating of your performance as an R.N.?

Your
overall per-
formance as
an R.N.

5
Performance
outstanding

4
Performance
noticeably
above average

3
Performance
adequate/
average

2
Performance
noticeably
below average

1
Performance
totally
inadequate

ADDITIONAL QUESTIONS FOR WAIT GRADUATES

1. You had certain expectations when you started work at _____.

You were looking forward to certain things and you also had certain apprehensions.

How has it turned out in fact?

(a) looking forward to:-

(b) apprehensions:-

QUESTION 4.

As you look ahead to the job and reflect on the course, what are the things i.e. skills and knowledge you believe you have that will contribute to your doing the job well?

Appendix 6

NPRF : MEAN SUPERVISOR RATINGS FOR SPECIFIC ITEMS

Key: Unless otherwise indicated, ratings are on a 4-point scale, as follows:

4 = Consistently

3 = Frequently

2 = Occasionally

1 = Rarely

(See NPRF in Appendix 2 for further details)

ROLE : HEALTH TEACHER

Competency Item	<u>WAIT GRADUATES</u>		<u>HOSPITAL GRADUATES</u>	
	Mean Rating	n* (max.8)	Mean Rating	n* (Max. 14)
1. Takes advantage of opportunities for teaching of				
a) patients	3.3	7	3.0	10
b) relatives	2.3	5	1.9	9
c) colleagues	2.5	6	2.1	9
2. Encourages questions from				
a) patients	3.4	5	2.6	10
b) relatives	2.2	5	1.8	7
c) colleagues	2.4	7	2.1	10
3. Is responsive to questions and/or "feelers" from				
a) patients	3.2	7	3.1	11
b) relatives	2.8	6	2.7	9
c) colleagues	2.9	8	2.6	12
4. Tailors explanations to suit the individual level of understanding of				
a) patients	3.0	6	3.2	11
b) relatives	2.7	6	2.8	8
c) colleagues	3.1	7	2.8	9
5. Explanations are appropriate to the needs and circumstances of				
a) patients	3.3	6	3.2	11
b) relatives	3.0	6	2.4	8
c) colleagues	3.1	7	2.6	11
6. Bases teaching on factually correct information	3.4	8	3.2	9
7. Refers patients/relatives/colleagues to appropriate sources of information when necessary (e.g. written information, other health agencies.)	2.7	5	2.9	6
8. Gives appropriate advice prior to discharge to				
a) patients	3.3	6	2.8	12
b) relatives	2.8	6	2.8	8
9. Modifies teaching plan, technique or approach when necessary	3.1	4	2.4	9
10. Assists other nursing personnel to develop their teaching ability.	2.1	7	2.0	9
11. Supports and reinforces the teaching activities of				
a) nursing colleagues	3.0	6	2.8	8
b) other health professionals	2.7	5	2.4	7
Overall rating (on 5 point scale)	3.31	8	3.17	12

* Indicates the extent of missing data, where supervisors were unable to provide ratings due to insufficient opportunities to observe, or supervisor ratings were unavoidable.

ROLE : PROVIDER OF CARE

Competency Item	<u>WAIT GRADUATES</u>		<u>HOSPITAL GRADUATES</u>	
	Mean Ratings	n* (Max. 8)	Mean Ratings	n* (Max.13)
<u>PLANNING CARE</u>				
2. Ensures that the care covers the full range of patient's needs.	3.2	7	3.0	12
3. Systematically utilizes relevant information.	3.3	6	3.1	11
4. The expected patient outcomes embodied in her plans for care are realistic/achievable.	3.1	7	2.8	10
5. In determining care to be given, involves				
a) the patient	3.4	7	2.9	10
b) the relative(s)	1.8	5	1.8	6
6. When appropriate, plans for continuing care	2.3	6	2.6	6
<u>IMPLEMENTATION OF CARE</u>				
7. Ensures that plans for care are followed through.	2.8	8	3.0	12
8. a) Involves the patient, when appropriate, in nursing care procedures.	3.1	8	3.2	12
b) Involves the relatives, when appropriate in nursing care procedures.	2.0	4	2.1	9
9. Is flexible in accommodating care procedures to patient's needs/wishes, when appropriate.	3.2	7	3.1	11
10. Practices in such a way as to ensure patient safety.	3.5	8	3.0	12
11. Is skillful in the performance of common procedures.	3.4	8	3.5	12
12. Is appropriately quick with procedures.	3.1	8	3.3	12
13. Provides for and maintains				
a) patient's physical comfort	3.8	8	3.8	12
b) patient's emotional well-being.	3.1	8	3.4	11
<u>EVALUATION OF CARE</u>				
14. Regularly updates and, when necessary, modifies plans for care.	3.1	8	3.1	12
15. In evaluating care given, utilizes feedback from				
a) patients	3.3	7	3.4	10
b) relatives	1.9	6	2.6	7
c) colleagues.	3.2	7	3.3	10
Overall rating (on 5-point scale)	3.9	8	3.7	12

* Indicates the extent of missing data, where graduates had insufficient opportunities to perform in this role, or ratings were unavailable.

ROLE : CO-ORDINATOR OF CARE

Competency Item	<u>WAIT GRADUATES</u>		<u>HOSPITAL GRADUATES</u>	
	Mean Rating	n* (Max. 8)	Mean Rating	n* (Max.14)
2. When nursing individual patients				
a) sets appropriate priorities for action	3.1	7	3.2	12
b) acts effectively on those priorities	3.1	7	3.3	12
3. When nursing groups of patients				
a) sets appropriate priorities for action	3.0	8	3.1	10
b) acts effectively on those priorities	2.9	8	3.1	9
4. Ensures that all the necessary materials/ resources are at hand before commencing procedures.	3.2	7	3.1	9
5. Carries out nursing care procedures concurrently when appropriate.	3.0	5	3.3	9
6. Arranges for continuing care of patients after discharge when appropriate.	2.2	5	2.4	8
7. Takes responsibility for co-ordinating all aspects of patient care (i.e. non-nursing as well as nursing care).	1.9	4	2.6	10
8. Co-ordinates nursing care with the activities of other staff so as to maximise patient well-being.	2.6	5	2.8	9
9. Willingly accepts responsibility for ward management	2.8	7	3.0	12
10. Assigns tasks and responsibilities to others appropriately (e.g. expertise workload, competence).	2.9	6	2.8	12
11. Effectively resets priorities in order to cope with emergency or untoward situations.	2.6	4	3.0	9
ITEMS 12 - 14 are on a 5-POINT SCALE.				
12. This R.N's performance as a supervisor of other staff.	3.1	8	3.1	11
13. This R.N's performance if in charge of a ward.	3.1	8	3.3	12
14. This R.N's performance as a co-ordinator of <u>individual patient care.</u>	4.0	8	3.8	12
Overall rating on 5-point scale	3.2	8	3.4	12

* Indicates the extent of missing data, where supervisors were unable to provide ratings due to insufficient opportunities to observe, or supervisor ratings were unavoidable.

ROLE : COMMUNICATOR

Competency Item	WAIT GRADUATES		HOSPITAL GRADUATES	
	Mean Rating	n* (Max. 8)	Mean Rating	n* (Max. 14)
<u>A. COMMUNICATING TO COLLEAGUES AND OTHER HEALTH PROFESSIONALS</u>				
VERBAL				
2. Is comprehensive	3.6	8	3.0	12
3. Information provided is relevant	3.4	8	3.4	12
4. Is clear and understandable.	3.4	8	3.4	12
5. Reports information accurately <u>WRITTEN</u> .	3.5	7	3.5	10
6. Is comprehensive.	3.4	8	3.5	10
7. The information provided is relevant.	3.5	8	3.6	11
8. Records information accurately.	3.4	8	3.6	10
9. The information required is systematically recorded.	2.9	8	3.3	11
10. Is clear and understandable.	3.3	8	3.5	11
11. Is attentive to legal responsibilities.	2.9	7	3.1	11
<u>B. COMMUNICATING TO OTHERS (E.G. PATIENTS, RELATIVES, COLLEAGUES AND OTHER HEALTH PROFESSIONALS.</u>				
12. Effectively communicates information regarding patient progress				
a) to the patient concerned.	3.0	8	3.0	11
b) to relative(s)	2.1	6	2.5	11
13. Treats patients as individuals.	3.5	8	3.8	12
14. Encourages the expression of thoughts and feelings of patients.	3.2	7	3.3	7
15. Makes sure that his/her communications are understood by				
a) patients.	3.2	7	3.4	7
b) relatives.	2.8	4	2.6	7
c) colleagues.	2.9	7	3.3	11
<u>C. RECEIVING COMMUNICATIONS FROM OTHERS (E.G. PATIENTS, RELATIVES, COLLEAGUES, AND OTHER HEALTH PROFESSIONALS</u>				
16. Is sensitive to non-verbal communications	3.1	4	3.0	12
17. Is an attentive listener				
a) to patients	3.3	8	3.5	12
b) to relatives	3.1	4	2.9	11
Overall rating (on 5-point scale)	3.8	8	3.9	12

* Indicates the extent of missing data, where supervisors were unable to provide ratings due to insufficient opportunities to observe, or supervisor ratings were unavoidable.

ROLE : MEMBER OF THE PROFESSION

Competency Item	WAIT GRADUATES		HOSPITAL GRADUATES	
	Mean Rating	n* (Max.8)	Mean Rating	n* (Max.14)
<u>RELATIONSHIPS WITH NURSING COLLEAGUES</u>				
In his/her relationships with nursing colleagues, this R.N:				
1. Practices in such a way as to promote the confidence & self-esteem of other nurses.	3.0	8	3.1	12
2. Treats nursing staff fairly.	3.3	7	3.3	12
3. Guides or assists other nurses appropriately	3.0	7	3.0	12
4. Show a preparedness to consult more experienced nurses when problems are beyond her expertise.	3.1	7	2.6	12
5. Accepts feedback regarding her performance modifying her behaviour accordingly	3.0	7	3.3	12
<u>RELATIONSHIPS WITH HEALTH CARE PROFESSIONALS/ OTHER STAFF.</u>				
In his/her work with Health Care Professionals/ Other Staff he/she:				
6. Facilitates effective working relationships with health care professionals.	3.0	6	3.0	12
7. Facilitates effective working relationships with other staff.	3.8	8	3.0	12
8. Works effectively within the policies of her employer.	3.2	5	3.3	12
9. Demonstrates preparedness to initiate changes when the organizational framework impedes patient care.	3.3	4	2.9	6
<u>PROFESSIONAL ATTRIBUTES</u>				
As a professional, this R.N:				
10. Accepts responsibility for her nursing actions and omissions.	3.4	8	3.6	10
11. Readily accepts the responsibilities assigned to him/her.	3.3	8	3.5	12
12. Does not allow personal feelings/beliefs to interfere with the quality of care given.	3.2	7	3.7	10
13. Maintains confidentiality of patients communications and information.	3.4	5	3.4	10
14. Respects the rights of patients.	3.8	7	3.6	12
15. Is reliable.	3.4	7	3.4	10
16. Demonstrates confidence in her nursing ability.	3.1	7	3.3	12
17. Practises effectively whilst under pressure.	2.5	7	2.9	9
18. Demonstrates an interest in her professional development by				
a) furthering her education	N/A		N/A	
b) participation in professional activities	N/A		N/A	
c) self evaluation of her practice.	N/A		N/A	
19. Acts effectively within the framework of his/her legal responsibilities	3.6	7	3.4	12
Overall rating (on 5-point scale)	3.8	8	3.7	12

* Indicates the extent of missing data, where supervisors were unable to provide ratings due to insufficient opportunities to observe, or supervisor ratings were unavoidable.

Appendix 7

NPRF : SELF RATINGS FOR SPECIFIC ITEMS

Key : Unless otherwise indicated, ratings are on a 4-point scale as follows:

4 = Consistently

3 = Frequently

2 = Occasionally

1 = Rarely

(See NPRF in Appendix 2 for further details)

ROLE : HEALTH TEACHER

Competency Item	WALT GRADUATES		HOSPITAL GRADUATES	
	Mean Rating	n* (Max. 8)	Mean Rating	n* (Max. 13)
1. I take advantage of opportunities for teaching of				
a) patients	3.8	5	3.3	12
b) relatives	2.6	8	2.5	12
c) colleagues	3.1	8	3.0	12
2. I encourage questions from				
a) patients	3.3	8	3.6	12
b) relatives	2.3	8	2.8	12
c) colleagues	3.0	8	2.9	12
3. I am responsive to questions and/or "feelers" from				
a) patients	3.3	8	3.5	12
b) relatives	2.6	8	2.9	12
c) colleagues	3.0	8	3.3	12
4. I tailor explanations to suit the level of understanding of				
a) patients	3.8	8	3.8	12
b) relatives	3.5	8	3.5	12
c) colleagues	3.6	8	3.8	12
5. My explanations are appropriate to the needs and circumstances of				
a) patients	3.6	8	3.3	12
b) relatives	3.4	8	3.2	12
c) colleagues	3.1	8	3.3	12
6. I base teaching on factually correct information.	3.8	8	3.6	12
7. I refer patients/relatives/colleagues to appropriate sources of information when necessary.	3.4	8	3.3	12
8. I give appropriate advice prior to discharge to				
a) patients	3.4	8	3.3	12
b) relatives	2.8	8	3.3	12
9. I modify teaching plan, technique or approach when necessary.	2.6	8	3.1	12
10. I assist other nursing personnel to develop their teaching ability.	2.4	8	2.1	12
11. I support and reinforce the teaching activities of				
a) nursing colleagues	3.3	8	3.0	12
b) other health professionals	3.3	8	2.8	12
Overall rating (on 5-point scale)	3.3	8	3.4	12

* Indicates the extent of missing data, where graduates had insufficient opportunities to perform in this role, or ratings were unavailable.

ROLE : PROVIDER OF CARE

Competency Item	WAIT GRADUATES		HOSPITAL GRADUATES	
	Mean Rating	n* (Max. 8)	Mean Rating	n* (Max. 13)
<u>PLANNING OF CARE</u>				
2. I ensure that the care covers the full range of patient's needs.	3.1	8	3.3	12
3. I systematically utilize relevant information.	3.0	8	3.1	12
4. The expected patient outcomes embodied in my plans for care are realistic/achievable.	3.7	6	3.2	10
5. In determining care to be given I involve				
a) the patient	3.0	8	3.4	12
b) the relative(s)	2.0	8	2.0	12
6. When appropriate, I plan for continuing care	2.4	8	3.2	12
<u>IMPLEMENTATION OF CARE</u>				
7. I ensure that plans for care are followed through.	2.7	7	3.3	12
8. a) I involve the patient, when appropriate in nursing care procedures.	3.4	8	3.3	12
b) I involve the relatives, when appropriate, in nursing care procedures.	2.3	7	2.4	12
9. I am flexible in accommodating care procedures to patient's needs/wishes.	3.1	8	3.3	12
10. I practise in such a way as to ensure patient safety.	3.8	8	3.8	12
11. I am skilfull in my performance of common procedures.	3.5	8	3.2	12
12. I am appropriately quick with procedures.	3.1	8	3.3	12
13. I provide for and maintain				
a) patient's physical comfort	3.8	8	3.4	12
b) patient's emotional well-being	3.4	7	3.0	12
<u>EVALUATION OF CARE</u>				
14. I regularly update and, when necessary, modify plans for care.	2.9	8	3.5	11
15. In evaluating care given, I utilize feedback from				
a) patients.	3.4	8	3.3	12
b) relatives	2.6	8	2.8	12
c) colleagues.	3.4	8	3.7	12
Overall rating (on 5-point scale)	3.6	8	3.6	12

* Indicates the extent of missing data, where graduates had insufficient opportunities to perform in this role, or ratings were unavailable.

ROLE : CO-ORDINATOR OF CARE

Competency Item	WAIT GRADUATES		HOSPITAL GRADUATES	
	Mean Rating	n* (Max. 8)	Mean Rating	n* (Max.13)
2. When nursing individual patients				
a) I set appropriate priorities for action	3.5	8	3.3	12
b) I act effectively on these priorities	3.1	8	3.3	12
3. When nursing groups of patients				
a) I set appropriate priorities for action	3.5	8	3.3	12
b) I act effectively on those priorities	3.1	8	3.3	12
4. I ensure that all the necessary materials/ resources are at hand before commencing procedures.	3.4	8	3.2	12
5. I carry out nursing care procedures concurrently when appropriate.	3.6	8	3.3	12
6. I arrange for continuing care of patients after discharge when appropriate.	2.5	6	2.9	11
7. I take responsibility for co-ordinating all aspects of patient care (i.e. non-nursing as well as nursing care).	2.4	7	2.6	12
8. I co-ordinate nursing care with the activities of other staff so as to maximise patient well-being.	3.3	7	3.3	12
9. I willingly accept responsibility for ward management.	3.1	8	3.1	12
10. I assign tasks and responsibilities to others appropriately (e.g. expertise, workload, competence).	3.5	8	3.2	12
11. I effectively reset priorities in order to cope with emergency or untoward situations.	3.1	7	2.8	12
ITEMS 12 - 14 ARE ON A 5-POINT SCALE				
12. My performance as a supervisor of other staff.	3.0	8	2.9	12
13. My performance if in charge of a ward.	3.1	8	3.3	12
14. My performance as a co-ordinator of individual patient care	3.6	8	3.7	12
Overall rating (on 5-point scale)	3.3	8	3.3	12

* Indicates the extent of missing data, where graduates had insufficient opportunities to perform in this role, or ratings were unavailable.

ROLE : COMMUNICATOR

Competency Item	WAIT GRADUATES		HOSPITAL GRADUATES	
	Mean Rating	n* (Max. 8)	Mean Rating	n* (Max. 13)
<u>A. COMMUNICATING TO COLLEAGUES AND OTHER HEALTH PROFESSIONALS</u>				
<u>VERBAL</u>				
2. I am comprehensive.	3.4	8	3.2	
3. The information I provide is relevant	3.5	8	3.3	
4. I am clear and understandable	3.6	8	3.0	
5. I report information accurately.	3.5	8	3.3	
<u>WRITTEN</u>				
6. I am comprehensive	3.5	8	3.4	
7. The information I provide is relevant.	3.9	8	3.5	
8. I record information accurately.	3.9	8	3.5	
9. The information I provide is systematically recorded.	3.6	8	3.1	
10. I am clear and understandable.	3.8	8	3.3	
11. I am attentive to legal responsibilities.	3.8	8	3.3	
<u>B. COMMUNICATING TO OTHERS (EG PATIENTS, RELATIVES, COLLEAGUES AND OTHER HEALTH PROFESSIONALS)</u>				
12. I effectively communicate information regarding patient progress				
a) to the patient concerned	3.4	8	3.1	
b) to relative(s)	2.9	8	2.9	
13. I treat patients as individuals	4.0	8	3.6	
14. I encourage the expression of thoughts and feelings of patients.	3.9	8	3.3	
15. I make sure that my communications are understood by				
a) patients	3.6	8	3.5	
b) relatives	3.4	8	3.1	
c) colleagues	3.6	8	3.5	
<u>C. RECEIVING COMMUNICATIONS FROM OTHERS (EG PATIENTS, RELATIVES, COLLEAGUES, AND OTHER HEALTH PROFESSIONALS)</u>				
16. I am sensitive to non-verbal communications	3.1	8	3.2	
17. I am an attentive listener				
a) to patients	3.5	8	3.3	
b) to relatives	3.0	8	3.0	
Overall rating (on 5-point scale)	3.6	8	3.3	12

ROLE: MEMBER OF THE PROFESSION

Competency Item	WAIT GRADUATES		HOSPITAL GRADUATES	
	Mean Rating	n* (Max. 8)	Mean Rating	n* (Max.13)
<u>RELATIONSHIPS WITH NURSING COLLEAGUES</u>				
1. I practise in such a way as to promote the confidence and self-esteem of other nurses.	3.3	8	3.3	12
2. I treat nursing staff fairly.	3.8	8	3.3	12
3. I guide or assist other nurses appropriately.	3.5	8	2.9	12
4. I show a preparedness to consult more experienced nurses when problems are beyond my expertise.	4.0	8	3.7	12
5. I accept feedback regarding my performance modifying my behaviour accordingly.	3.7	8	3.3	12
<u>RELATIONSHIPS WITH HEALTH CARE PROFESSIONALS/ OTHER STAFF</u>				
6. I facilitate effective working relationship with health care professionals.	3.8	8	2.9	12
7. I facilitate effective working relationships with other staff.	3.6	8	3.3	12
8. I work effectively within the policies of my employer.	3.4	8	3.5	12
9. I demonstrate a preparedness to initiate changes when the organizational framework impedes patient care.	2.9	8	2.7	12
<u>PROFESSIONAL ATTRIBUTES</u>				
10. I accept responsibility for my nursing actions and omissions.	3.9	8	3.4	12
11. I readily accept the responsibilities assigned to me.	3.6	8	3.6	12
12. I do not allow personal feelings/beliefs to interfere with the quality of care given.	3.8	8	3.3	12
13. I maintain confidentiality of patients communications and information.	4.0	7	3.6	12
14. I respect the rights of patients	3.9	8	3.7	12
15. I am reliable.	3.5	8	3.5	12
16. I demonstrate confidence in my nursing ability.	3.0	8	3.3	12
17. I practise effectively whilst under pressure.	2.9	8	3.1	12
18. I demonstrate an interest in my professional development by				
a) furthering my education	3.4	8	2.6	12
b) participation in professional activities	3.0	8	2.0	12
19. I act effectively within the framework of my legal responsibilities.	3.4	8	3.5	12
Overall rating (on 5-point scale)	3.1	8	3.3	12

* Indicates the extent of missing data, where graduates had insufficient opportunities to perform in this role, or ratings were unavailable.